

HARVARD MEDICAL

Alumni Bulletin

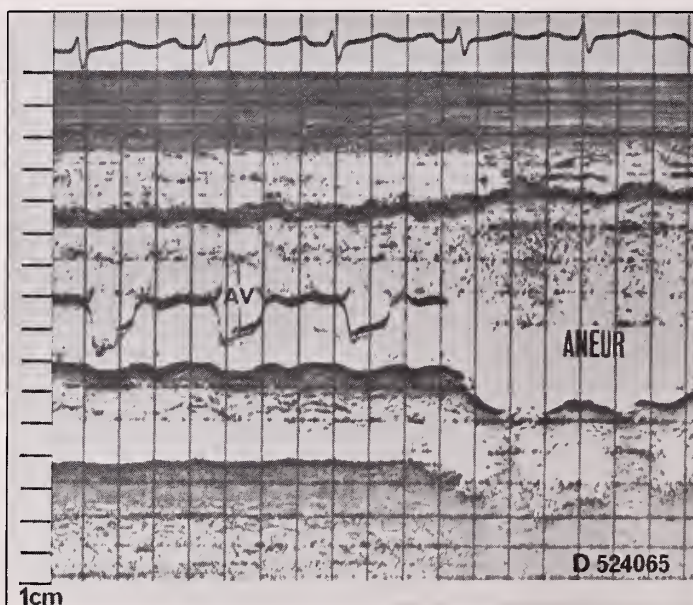
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Edited and with contributions by **Eugene Braunwald, MD**, Hersey Professor of Theory and Practice of Medicine and Head, Department of Medicine at the Peter Bent Brigham Hospital, Harvard Medical School; Physician-in-Chief, Affiliated Hospitals Center, Boston. About 2102 pp. Illustd. Ready April 1980. Single Vol.: \$65.00. **Order #1923-1.** 2-Vol. Set: \$75.00. **Order #1924-X.**

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April 1980
volume 54 number 3

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Upping the ante

Tuition is one aspect of a Harvard Medical education that cannot remain constant, and few expect it to. Yet on February 21 there was no joy around the Quadrangle when medical and dental students received official word of a twenty percent tuition increase — from \$6500 to \$7800; last year a thirteen percent hike was levied. Other Harvard graduate students will incur charges for 1980-81 that average 13.6% above those for the current academic year.

The medical and dental schools are hit particularly hard by inflation (which was thirteen percent at the time of this announcement), by prohibitive energy costs, and by dwindling government support. Endowment income grows at an annual rate of only four percent, while the expenses it supports are in the invincible grasp of inflation. According to Dean Tosteson, approximately \$700,000 annually disappears because of this gap and, in effect, the endowment reserves are slipping by some twelve million dollars a year.

Mitchell Adams, Dean for Finance and Business, commented that medical education is of an "energy-intensive" nature and HMS's investment in fuel certainly proves that point. The cost per barrel of oil jumped from \$16 to \$33 within the past year and the administration — perhaps with its fingers crossed — has budgeted an average price of \$44 for fiscal 1981. Consequently, the Medical School will feel the pinch of an additional two million dollars in unavoidable expenses. And the escalating capital costs of the Medical Area Total Energy Plant (MATEP) have

played a decidedly major role in catapulting tuition to new heights.

The deleterious effects of exorbitant energy costs and inflation have been subtly aggravated by changes in federal policy. Whereas the government continues to help defray the cost of medical education, the amount of that support is shrinking. That capital funds are expected to be cut by \$500,000 in the coming year does not bode well for the School's finances.

Students and their families may be consoled by the fact that the new price tag for one year at Harvard Medical School is about equal to the average tuition costs at all other private schools. "As in past years," stated Tosteson, "financial aid will be available to meet the requirements of all students, and scholarship funds will be increased proportionately with tuition." But the current revenues will surely be spread more thinly than ever as the Medical School actively seeks broad-based support to ensure the continued excellence of its academic offerings.

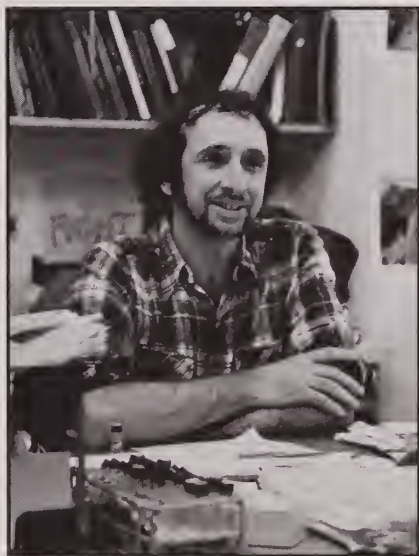
Cancer professorship goes to geneticist

Jonathan Beckwith, Ph.D., professor of microbiology and molecular genetics, has been singled out with the award of a career-long American Cancer Society Research Professorship. According to the Cancer Society, these academic titles are held by "approximately twenty of the nation's most gifted scientists who have made

outstanding contributions pertinent to cancer research."

For the first dozen years of his seventeen year career Beckwith explored the ways in which genes are regulated. Working with the lac operon, a set of genes involved in lactose metabolism, he and his colleagues discovered and described in fine genetic detail the "promoter" or site on the DNA that initiates the copying of DNA into RNA. 1969 marked the year that the labors of Beckwith and his colleagues bore fruit. In conjunction with their analyses, they isolated a single lactose gene; this was heralded as a crucial step in understanding the function of genes and won Beckwith the Eli Lilly award in 1970.

In the past five years he has studied how proteins are secreted across cell membranes. It is known that mistakes in protein transport can cause cells to malfunction or even to die and that the cumulative damage may prove fatal to the organisms to which they belong. In 1977 he and his colleagues demonstrated what had been only hypothesized before, namely, that proteins destined for secretion through the bacterial membrane differ in their composition from those that are to stay within the cell. They found that proteins meant to be exported are made with a signal sequence that is positioned at the amino-terminal end of the chain; the signal is essential to promote the protein secretions. In a further development, the investigators devised a series of ingenious experiments that — by an alteration of the portion of the protein's DNA that codes for the signal response — prevented a protein destined for secretion from passing through the membrane. They then



Jonathan Beckwith, Ph.D.: the factors of protein transport

proved that the major feature of the signal sequence is hydrophobia. The converse holds true as well — that a protein directed by a faulty signal exhibits hydrophilia, and will be unable to proceed through the membrane.

Having determined that a signal either pushes a protein on or holds it back, Beckwith's lab now is engaged in trying to ascertain the components within the membrane that help these proteins on their journey. The object, states Beckwith, is to find a situation where all of the proteins are inhibited from moving towards the membrane. "If we can find such a mutant bacteria," he explains, "then we can look at it and ask, What's wrong with it? Where did we go wrong? What component of the bacterial membrane have we messed up? That will give us a handle on finding the important component of the bacterial membrane." Yet it will be hard to circumvent the main obstacle to the successful implementation of this strategy. According to Beckwith, cells that are prevented from secreting their proteins are presumed to die. What is therefore required, he continues, is finding a bacterial cell that will secrete its proteins under just one condition, such as at a low temperature. "And then we'll have to find a way to screen a cell for a defect in secretion while it is not growing."

The complexities of genetic research soon made Beckwith especially sensitive to social and political practices that could arise on this new scientific frontier. At a national press conference in 1969, he and three of his colleagues expressed their concern that developments in molecular genetics were leading to the possibility of human genetic engineering and that they would be powerless to prevent any negative consequences that might occur as a result of their work. Their statements started up a controversy that has by no means run its course. Throughout his career Beckwith has been active in Science for the People, an organization that opposes the misuse of science and technology. He objects strenuously to claims — by scientists and others — that genetics is a determinant of behavior or intellect, and feels strongly that these new genetic tools should not be allowed to jeopardize social progress. A notable example is susceptibility screening, which is useful in particular medical diagnoses — physicians can now detect people who are prone to hypercholesterolemia and prescribe appropriate diets. Yet susceptibility screening is not always used for such altruistic purposes. Many industrial companies now routinely test workers to determine whether their genetic makeup predisposes them to diseases related to particular chemicals in the workplace. "But industry's solution," Beckwith stresses, "is not to get rid of the pollutants which affect all people but rather to suggest that those individuals thought to carry the genetic susceptibility be removed from the workplace."

Beckwith does not characterize himself as a cancer researcher. Nevertheless, he believes that the award from the Cancer Society confirms the need for independent basic research, which forthrightly refuses to promise one or another cure. "An understanding of the mechanisms of protein transport across membranes has the potential for being useful in figuring out something about how cells grow and develop. And maybe about why cells turn cancerous, but it is not certain that would happen. Finding out something about how new mem-

branes change may well be relevant to cancer. But cancer is being attacked from a whole host of different angles, and it is not clear which one, if any, is going to be successful."

Ingram awarded chair in pulmonary medicine

The secure future of the Division of Respiratory Medicine at the Peter Bent Brigham Hospital is in large part a reflection of the magnanimity and commitment of the Parker B. Francis family. In 1973, the Francis Foundations helped enable the division at the Brigham to take firm root. That largesse was more than equaled by the gift last March of a professorship to the Harvard Medical School. Dr. Ronald H. Ingram, Jr., director of the division since its inception, has been named the first Parker B. Francis Professor of Pulmonary Medicine. Seven years ago, Ingram had only one colleague, Dr. E. R. McFadden, Jr.; since then six more full-time physicians have been added, two of whom are at the West Roxbury Veterans Administration Hospital. The division, still in its youth, nevertheless has already initiated a number of innovative research, teaching, and postdoctoral programs at the Brigham and other hospitals.

In their outside collaborations, members of the division have worked with the chest division and the pathology department at Children's Hospital Medical Center, under the direction of Dr. Lynne Reid; the physiology group headed by Dr. Jere Mead at the School of Public Health; and several research groups at MIT, to name a few. Ingram notes that "helping to bring together a group of previously unrelated research groups is a special contribution of this unit."

The division has undertaken investigations of exercise-induced asthma and come up with "some very exciting and rewarding results," he added. Ingram and McFadden were able to

demonstrate that when airway obstruction is brought on by exercise, the primary stimulus is respiratory heat loss during the exercise period; the degree of obstruction that occurs is directly proportionate to the amount of heat lost. They determined that when the air is preconditioned to body temperature and water content respiratory heat loss and obstruction are prevented.

The same relationship affects non-asthmatic individuals, but a response in them is triggered only by a much greater loss of heat. Through the use of more sensitive measurements, the Brigham researchers showed that small but significant changes do occur in people free of asthma. Their studies indicated that, as with other non-antigenic airway challenges, the variances between people with and without asthma is purely quantitative.

The respiratory division is also directing its energies into research on the enigma of sleep apnea. Two standard treatments are electrical stimulation of the phrenic nerve (when breathing stops completely) and

tracheostomy (when breathing efforts continue and intensify, but are ineffectual because of airway obstruction). Postulating that sleep apnea may follow the failure of the central nervous system to coordinate its output to the necessary muscle groups, Ingram and his associates have successfully used respiratory stimulants such as progesterone to treat this condition.

Farber administration in new hands

Baruj Benacerraf, M.D., the Farbyan Professor of Comparative Pathology and chairman of the department of pathology, is ready to begin work July 1 as president and chief executive officer of the Sidney Farber Cancer Institute. Emil Frei III, M.D., who has been director and physician in chief since 1973, will continue to execute his responsibilities for

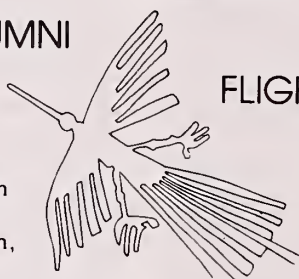
clinical and clinical research programs, but will be relieved of the institute's burgeoning administrative concerns.

A distinguished immunologist, Dr. Benacerraf served two years as chief of the laboratory of immunology, National Institute of Allergy and Infectious Disease, before joining the HMS faculty in 1970. His research interests have centered most recently on basic mechanisms of immune responsiveness and tolerance. He has contributed to the discovery of immune response genes that control the recognition of specific antigens and has been investigating the processes that these genes command in the immune response. In earlier work, Dr. Benacerraf shed light on the mechanisms of both humoral and cellular hypersensitivity reactions and of the pathogenesis of glomerulonephritis and allergic vasculitis. He also has contributed to the demonstration and study of cancer specific antigens.

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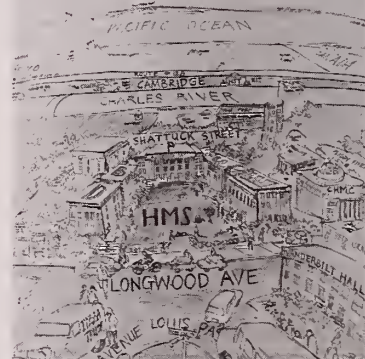
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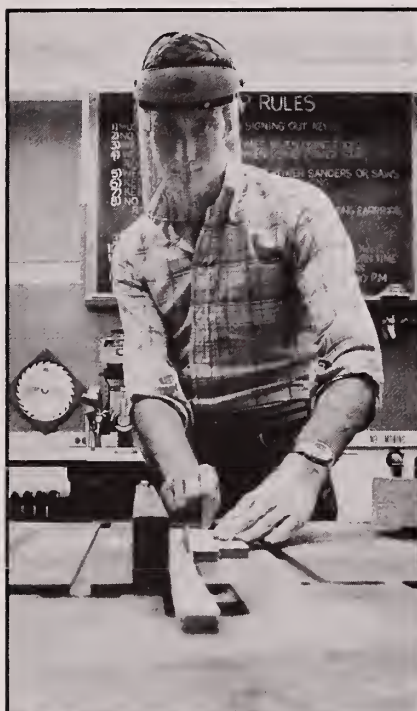
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Harvard Alumni College in Cambridge 1980

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A Progress Report

by Robert S. Lawrence

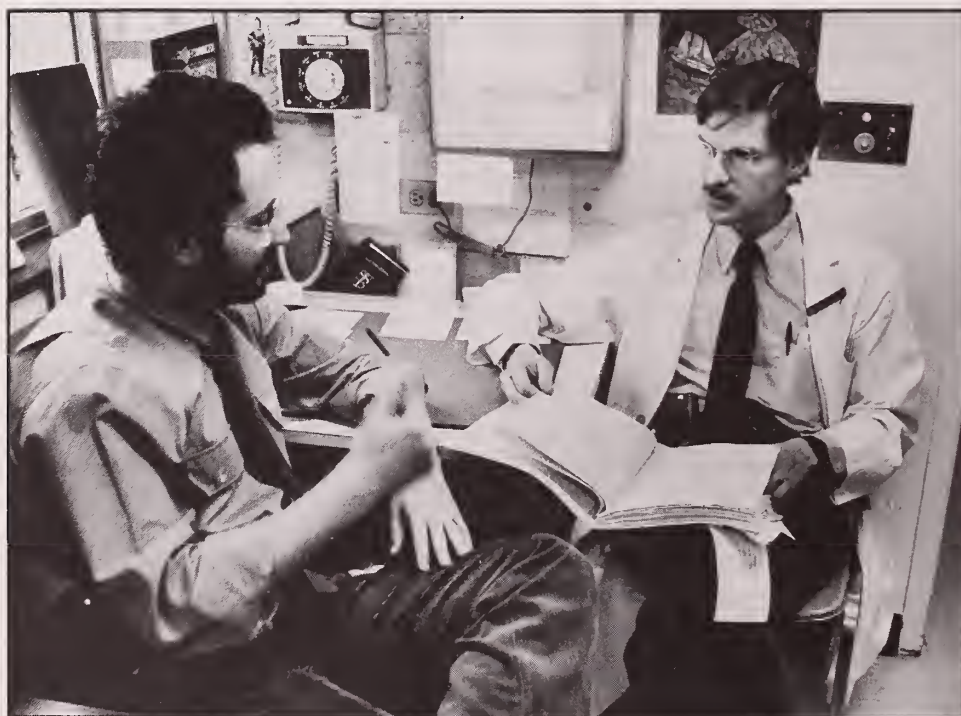
Harvard's Primary Care Program has created its own identity

Much has happened in the six years since the *Alumni Bulletin* last devoted a special issue to family medicine and primary care at Harvard. Residency programs in primary care internal medicine were then in their infancy, only a few trainees were involved, student electives were just being planned, and post-residency fellowships were still merely wishful thoughts. Today, five Harvard teaching hospitals have seventy residents training for careers in primary care. A dozen sites provide ambulatory experience in settings that range from small neighborhood health centers to the comprehensive facilities of the Harvard Community Health Plan. Emphasis on primary care in the undergraduate curriculum at HMS is growing, and the recently established Kaiser Fellowship Program in general internal medicine may begin to

redress the critical shortage of teachers and role models for students interested in generalist careers. These developments are discussed elsewhere in this issue. This article will briefly review the history of the primary care residency programs as well as present data on the opinions of the trainees regarding their experiences.

By the early 1970s the post World War II trend toward specialization in medicine had reached alarming proportions. Although there were roughly 160 physicians per 100,000 people, fewer than twenty-five percent were in the primary care disciplines of general practice, family practice, general internal medicine, or general pediatrics.

The number of medical school graduates entering general practice had been decreasing steadily for years, and GPs who died or retired were seldom replaced. In 1931



Crossing hierarchical bounds: Robert Lawrence, a physician in the Beth Israel Ambulatory Care Center, talks over a case with Daniel Einhorn, a BIAC junior resident.

more than eighty percent of the practicing physicians were general practitioners; by 1972 the figure had dropped below twenty^{1,2}. The failure of other types of primary care physicians to provide a quantitative replacement has had widespread effects on the average American's ability to secure basic health services. Despite the emergence of some 70,000 general internists and pediatricians to take up part of the slack, more and more patients have turned to hospital emergency rooms, outpatient departments and other less appropriate sources of primary care because they lack adequate alternatives. Just in the period from 1970 to 1973, visits to hospital emergency rooms increased by fifty percent; most of the increase reflected a need for primary, rather than emergency, care.

These changes did not go unnoticed by the federal government, which has always viewed medical education as a major vehicle for the resolution of health care problems. Three decades ago the emphasis was on the expansion of biomedical research capabilities; during the 1960s the number and capacity of medical schools were expanded as a means to relieve the shortage of physicians, and during the 1970s geographic and specialty maldistribution have emerged as the most critical issues.³ In 1974, the Coordinating Council on Medical Education set as a goal the selection of primary care careers by fifty percent of medical graduates,⁴ and two years later this goal was translated into a requirement. The federal Health Professions Educational Assistance Act (94-484) stipulated that by 1979 half of those completing medical school would have to enter training in the primary care specialties of family practice, internal medicine, or pediatrics. Schools that failed to meet this quota would forfeit capitation funding.

The credibility of internal medicine's claim to identification as a primary care discipline is threatened by the fact that approximately seventy percent of internal medicine trainees in 1976 went on to subspecialty fellowships.⁵ Recent data suggests that this percentage has dropped to sixty or less, but it remains a source of great concern that so many internists are training as subspecialists when manpower projections show that by 1990 the number of internists will be more than double the number of family practitioners and GPs.

Internal medicine residency programs have responded slowly to the pressure for more primary care training. Of the 418 programs included in the National Study of Internal Medicine Manpower in 1976 the average schedule assigned just under fifteen percent of a three year residency to ambulatory rotations. However, sixty-four percent of the programs claimed to be increasing ambulatory training or planning to do so in the near future.⁶ Presently, about sixteen percent of all internal medicine residency programs have special primary care tracks which then account for just less than ten percent of the residency positions in internal medicine.

In 1973, against this backdrop, internal medicine residency directors at the Beth Israel, Massachusetts General, and Peter Bent Brigham hospitals and the Harvard Com-

munity Health Plan established a small pilot program to train internists who would organize, teach, and deliver primary care services.^{7,8,9} The program began with six residents who embarked on a training course that was significantly different from traditional programs in internal medicine. A larger proportion of time was devoted to general ambulatory care and to encounters with patients who had clinical and diagnostic problems more commonly found in office practices than in the hospital.

With this initial endeavor underway, the Robert Wood Johnson Foundation agreed to support an expanded program that would include the Cambridge and Mount Auburn hospitals as well as ambulatory units at the Beth Israel and the Peter Bent Brigham. A course at the Harvard School of Public Health in clinical epidemiology and the organization of medical care, and a central program office at the Harvard Medical School were also funded.

The new residency tracks emphasized interviewing, the doctor-patient relationship, psychological treatment techniques, the diagnosis and treatment of psychiatric illnesses, the recognition of psychosocial pathology, and collaboration with social workers, nurse practitioners, and mental health workers in order to coordinate personal health services.

While psychiatry may be the component most conspicuously absent from traditional internal medicine residencies, there were other missing parts almost as important. From the outset the primary care faculty recognized that if they were to accomplish the overall objectives of the primary care program, they would have to: describe the body of knowledge, skills, and interdisciplinary relationships that characterize primary care; develop a curriculum to train primary care physicians; characterize the type of trainees that should be included, the criteria for their selection, and the resources that would be required to implement the program; define the characteristics, qualifications, and criteria for the recruitment, organization, and academic promotion of its faculty; and identify or develop appropriate facilities for the ambulatory element of training.

In 1975-76 the Association of American Medical Colleges funded a group of Harvard physicians, led by Charles Hatem '66, to work with faculty members from five other medical schools on a contract with HEW; their charge was to develop training programs that would prepare physicians for practice in HMOs. The Harvard group addressed itself to the formulation of educational objectives for the primary care residency program with specific attention to the germane non-internal medicine subjects — dermatology, office gynecology, psychiatry, non-operative orthopedics, ENT, and ophthalmology. The second phase of curriculum development focused on the disciplines of internal medicine. Certain questions were asked. For example: How much cardiology should a primary care internist know? And should he or she know how to pass a Swan-Ganz line, or is it sufficient simply to recognize when it's appropriate to call a consultant in to pass one? As in their earlier work on the non-internal medicine areas, the primary care faculty members first prepared several drafts of objectives and then conferred with colleagues representing each of the specialties under consideration. By means of a highly iterative process the generalist and the specialist

Robert S. Lawrence '64 is the director of the Division of Primary Care and Family Medicine. He is also associate professor of medicine and preventive and social medicine at the Beth Israel Hospital.

“The Harvard group addressed itself to the formulation of educational objectives for the primary care residency program with specific attention to the germane non-internal medicine subjects.”

decided what areas had been inappropriately included or excluded and afterwards wrote a new draft. Finally, the goals that emerged from this give-and-take were taken into account as a curriculum was devised and decisions were made regarding the length of rotations, the optimal patient mix, the content of didactic sessions, and the specific criteria for the examinations given at the beginning and end of training. The resulting ideal was a curriculum based not on time spent, but rather on the competence achieved. For the present, however, the fiscal and service needs of the participating institutions and the time-based requirements of the American Board of Internal Medicine will discourage the implementation of training programs that are in fact competency-based.

Except at the MGH, where forty percent of the intern-

ship is spent in the primary care unit,¹⁰ in their first year primary care trainees have the same inpatient schedules as their traditional counterparts. One session weekly is devoted to the primary care unit at each hospital, as the interns begin to build a panel of patients that they will care for throughout the years of the residency. At each of the hospitals, the trainees' second and third years are split down the middle. The residents spend half of their time at one of the primary care program's twelve sites, in ambulatory work that is divided evenly between general medicine and the specialty skills essential to primary care practice; the remainder is devoted to traditional inpatient and subspecialty rotations. For the general medicine sessions each resident, as a member of a team composed of a staff physician, a nurse practitioner, a social worker, a

The Next Step: Faculty Development

“Primary care training is in a transition period, and most faculty come to these divisions [of general internal medicine] by circuitous routes: some may have had specialty training and some no training at all beyond their residencies,” asserts Thomas Delbanco, associate professor of medicine and chief, section of general internal medicine and primary care at Beth Israel Hospital. According to him, generalists have not had the opportunity to become as well grounded in clinical research methodology as have their subspecialist colleagues. At the same time, a remarkable proliferation of divisions of general internal medicine has left many faculty positions unfilled. One of the public-spirited institutions that is concertedly working to fill the ranks of primary care academicians is the Henry J. Kaiser Family Foundation. The ninth and largest Kaiser Fellowship Program has been inaugurated at Harvard under the direction of Delbanco. A grant of one million dollars for the next four years will support the training of twenty-three generalists — twenty in primary care and three in geriatrics — for academic careers.

As the director, Delbanco shares program responsibility with associate directors Lee Goldman, assistant professor of medicine and staff member of the Division of General Medicine at the Peter Bent Brigham Hospital and Al Mulley, instructor in medicine and co-director of the Medical Practices Evaluation Unit at the Massachusetts General Hospital.

Actually, primary care at Harvard has been waxing strong for several years. With sixty-three residents dispersed throughout the system, the Division of Primary Care and Family Medicine has made a respectable name for itself as one of the largest training centers in the country. The first group of five Kaiser Fellows (six will be chosen for each of the next three years) was selected from among participants in HMS postgraduate programs: David Bor, Arnold Epstein, Mark Moskowitz, Elaine Shiang, and Daniel Singer. All have completed residencies in internal medicine and four came from special tracks in primary care. (In the future fellows will be drawn both from programs at Harvard and elsewhere.) Kaiser Fellows all have appointments at Harvard and at their respective sponsoring clinical sites,

where they put their incipient teaching capabilities to the test. The hospitals currently affiliated with the program are the Beth Israel, the Massachusetts General and the Peter Bent Brigham. Next year Cambridge Hospital will be involved and it is expected that Mt. Auburn Hospital and the Harvard Community Health Plan will ultimately become active partners as well.

The scope of the two-year training is designed to meet four principal objectives. First, the acquisition of scholarly skills, particularly in the fields of clinical epidemiology and decision analysis, are mandatory so that the Fellows will be able to conduct research that can both contribute to general medicine and improve the efficacy and efficiency of medical practices. Second, since these young physicians will be instrumental as role models for the next generation of generalists, the development of teaching skills is vital. Third, through exposure to general medicine settings that integrate office and hospital care, their clinical skills will be precisely honed. Fourth, and perhaps the most fundamental goal, adds Delbanco, is to “build a cohesive Harvard-wide community of fellows with a definite group identity that goes beyond their individual institutions.”

Those in primary care are fre-

health assistant, and a medical secretary, cares for his or her own patients. Dietitians, psychiatrists, and other health professionals are available to back up these primary care teams. During the sessions assigned to dermatology, orthopedics, and the like, the resident is both a participant and an observer in the learning process.

In the final year of training, the resident takes on a larger teaching role, and is allowed greater independence to practice and to design elective experiences of special interest as he or she prepares to enter practice. The range of ambulatory sites provides a diverse experience in practices based in hospitals, neighborhood health centers, HMOs, student health services, and private physicians' offices.

The organization of ambulatory services that provide high quality primary care to defined populations was a prerequisite for the teaching activities of the Harvard Primary Care Program. The Harvard Community Health Plan, which opened in late 1969, now serves 80,000 people in two prepaid group practices used by four of the primary care residencies. The primary care unit at the MGH was established as part of the medical clinics in 1973 — when the pilot program in primary care began — and now is the base for four primary care teams, each with four residents. In 1972 the Beth Israel Ambulatory Care Center (BIAC) replaced the entire range of general medical, obstetrics-gynecology and

mental health clinics in the outpatient department.¹¹ This hospital-based primary care center was one of the first in the United States to bring in full-time faculty teams to replace the voluntary staff who had served in the traditional clinics. Similar steps were subsequently taken at the Peter Bent Brigham, Mount Auburn, and Cambridge hospitals. In some instances the emergence of primary care units has fostered and facilitated the development of training programs within tertiary care institutions, while in other cases the training needs have stimulated the hospitals to move ahead more rapidly in the commitment of space, personnel, and funds for primary care practices either within their walls or in affiliated sites.

Further growth of the program is currently limited by a shortage of ambulatory space and the costs incurred by trainees and faculty in the teaching practices. Four sites were studied in 1975-76,¹² and it was determined that teaching, administrative, and patient service costs averaged just over \$3,000 per trainee per month. Billings for the patient services supplied by those residents yielded revenues of \$2,500 per month, or seventy-seven percent of the total cost. Without the initial foundation grants, and, since 1977, funding by the Bureau of Health Manpower, DHEW, the program could not support the current mix of education and service opportunities for primary care residents. The

quently concerned with issues that examine the dynamics of medical care in a broad context: clinical epidemiology, decision analysis, microeconomics and related policy matters, and the behavioral sciences. The Kaiser Fellows follow an intensive core curriculum in the first six months that addresses the first three of the above topics, and directs special attention to applied biostatistics and the use of computers. After the completion of their core studies, they initiate a research program at their respective clinical base that relates to either clinical epidemiology or decision analysis; by the end of the two years, they must have demonstrated competence in both areas.

At the medical practices evaluation unit at the MGH, Dan Singer is studying patients who are readmitted to medical intensive or coronary care units due to unexpected complications. Being able to accurately predict such complications might result in more prudent allocation of intensive care resources as well as improved patient outcomes. David Bor, at the BI, is evaluating one customary hospital procedure — that of taking blood cultures of all febrile patients — in an attempt to define when such lab work is indicated. Elaine Shiang, working at the Peter Bent and the Boston Hospital for

Women, is grouping together those gynecologic skills that should be in the domain of the general internist. Arnold Epstein, also based at the Brigham, is concerned with physician test-ordering behavior in such diverse practice settings as prepaid health plans, and both hospital-based group and traditional office practices. And Mark Moskowitz, situated at the BI, is applying the principles of decision analysis to the radio-immune assay acid phosphatase test. Used increasingly to screen for carcinoma of the prostate, this test has been implemented with little thought as to its cost-effectiveness and cost-benefit implications.

A salient feature of the Kaiser Fellowship Program is the case study format. A prominent investigator gives a seminar, but the scientific tables are reversed. At the beginning of Frank Speizer's presentation on the relationship of hair dyes to cancer, for example, the Fellows did all of the talking. They had been assigned five background papers in order to enable them to hypothesize which epidemiologic methods would be appropriate in investigating a possible association. Speizer critiqued their proposals before revealing his own methods and data. Other visiting faculty and their research projects have

included: Edward Kass, Channing Professor of Medicine, HMS: a recent major clinical trial that demonstrates the efficacy of therapy for mild and moderate hypertension; William Kannel, professor of medicine at Boston University: the methodology and some of the results of the Framingham Study, of which he is former director; William Schwartz, University Professor at Tufts: a recent examination of the role of market forces in determining the distribution of physician manpower; Hershel Jick '56: a review of the Boston Collaborative Drug Study, which he heads; Rashi Fein, professor of the economics of medicine, HMS: new issues in the national health insurance debate; and Sheila Burke, senior minority staff member of the U.S. Senate Finance Committee: the legislative process. Once a year all of the fellows travel to Washington to exchange views with legislators and policymakers who work on health practice and research issues.

The Kaiser Fellowship Program will surely act as a much-needed catalyst for faculty development. Young physicians who themselves have the requisite expertise in clinical diagnosis, treatment, and research will instill a valuable measure of scholarship into the education of future primary care specialists.

Hospital	Still in primary care training	In other training:		Primary care practice:		Other
		non-PC	PC fellow	academic	non-academic	
BIH	10	3	2	1	5	2
CH	18	4	1	4	6	5
MGH	17	5	0	7	2	1
MTAH	12	4	0	0	5	1
PBBH	13	5	4	4	4	1
Total	70	21	7	16	22	10

participating hospitals have already made generous contributions to the program, and short of allocating some of the costs to the day rate, it is unlikely that the hospitals will be able to bear more of the teaching expenses.

Are the costs and effort worth it? Two modest evaluative efforts have attempted to answer this question. The first is in the form of an annual questionnaire in which the residents are asked for their opinions on the quality of the teaching, the appropriateness of the schedule, and so on. The second is a simple demographic profile of each trainee, updated regularly, that indicates how many actually end up as primary care internists.

The following are representative responses to the questionnaire completed in June 1979 by forty-six of the primary care residents. While eighty percent thought that the experience as a member of a primary care team was "somewhat important" or "very important," only sixty-eight percent thought that the quality of the experience in their program was "good" or "very good." Similarly, seventy-one percent considered it important to have the opportunity to share a panel of patients with a nurse practitioner, but only fifty-six percent rated their experiences as "good" or "very good." Responses to a question about the importance and quality, respectively, of continuity and integration of experiences between the ambulatory and inpatient rotations were seventy-four percent and forty-six percent. Not surprisingly, eighty-seven percent of the respondents said that it was important to have ambulatory rotations during the internship, but only a disappointing fifty percent regarded their rotations as "good" or "very good." Clearly, the program has done well in providing the kinds of experiences our trainees seek, but has fallen short of their expectations in terms of quality.

Questions about the factors that influence future choices revealed that fifty percent thought it important to have some combination of subspecialty and primary care practice. (Are we putting old wine in new bottles?) Patient payment mechanisms were considered important by fifty-two percent with a majority preferring prepayment to fee-for-service. An overwhelming ninety-one percent of the residents said they wanted a nurse practitioner in their practice.

A global question about the overall quality of the primary care program found that thirty-nine percent of the residents rated it as "good," forty-eight percent as "very good," and only four percent as "poor" or "very poor." If given the opportunity, ninety-one percent would choose the program again.

The table above describes the current status of the 146 residents who have had at least one year of training in the Harvard Primary Care Program (1973 - present).

A sobering conclusion must be drawn from these statistics: despite training programs that were highly regarded by the trainees and that would be chosen again by the great majority of respondents to an anonymous questionnaire, a substantial number of graduates end up in specialty practice. The challenge for the Harvard Primary Care Program is to identify those factors — the reimbursement system, the demands of practice, the fear of having to know too much about too many fields — that influence career choice away from primary care, and then to counter them and to improve our methods of selecting trainees. We need to find ways to select those applicants who will, in all probability, remain committed to primary care. Unless the yield from our program improves, it will become more difficult to attract continued financial support, from either private or public sources. Yet a more detailed examination of the data shows that many of the "drop-outs" left in the early years of the program and that we are indeed doing better with the more recent trainees. In the interest of the program's ongoing vitality, all of us involved in the Harvard Primary Care Program hope that such improvement will continue.

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The doctor behind the otoscope is Carol Jessup, second year resident at the MGH.

Honorable Intentions

Six ways of looking at a primary care residency

"If you're really interested in the primary care program, talk to the residents." This was the suggestion, a good, obvious one that nevertheless had not occurred to me before. But of course: the actual, subjective experience of a training program — for the people being trained — is bound to deviate from what the planners, administrators, and faculty imagine and intend it to be. For instance, well over half of the trainees in general internal medicine accept subspecialty fellowships at the conclusion of their residencies. This high "failure" rate is a statistical thorn in the sides of the primary care proponents who have fought to establish such programs. But what about the current group of incipient internists? How many of them plan to practice as generalists? And the ones who don't, why did they choose primary care residencies in the first place? Did they, do they feel that it is just a better, fuller way to train, along the road

to subspecialty careers, a sort of postgraduate medical equivalent of the liberal arts education? These seemed like important questions. So I talked to the residents.

I interviewed six people. Earl Steinberg and Thomas Sterne are both interns at the MGH — the only hospital in the Harvard program where a significant portion of the first postgraduate year is devoted to ambulatory training. Celeste Robb-Nicholson and Ronald White are junior residents at the Brigham. At the Beth Israel, Daniel Einhorn is in his first residency year in primary care (last year he was a psychiatric resident there), and Betsy Weiss is within a few months of finishing the program. She will join the Indian Health Service next year, in Bethel, Alaska, where she will divide her time between work in the area's sixty-bed referral hospital and practice out in the surrounding communities.

Most of the six, when they were in college, eschewed the standard premedical tracks in favor of the humanities or the social sciences, and most of them, either before or during medical school, did graduate work in other fields. In college, Robb-Nicholson majored in history and literature, did social work, and then a year after graduation entered a school of public health. Steinberg, who concentrated in psychology and social relations as an undergraduate, took a year out of medical school to get a masters in public policy. "When I was in college," Sterne admitted, "I'm sure I didn't know the difference between an oral and a rectal thermometer." He took his first premed courses only after he had earned a masters at the London School of Economics. White started with a college major in intellectual history, then went to divinity school, studied the theory and practice of group therapy, worked as a group counselor, taught meditation and dance, and learned Hebrew and Greek. At thirty-six, he's the oldest resident I spoke with.

For the interviews, I went to the residents, and found them in their elements — more or less. Einhorn, Sterne, and Steinberg were at home in their clinic offices, but to find Robb-Nicholson I had to trek up Parker Hill to the Robert Breck, where she was on an inpatient rotation. Weiss was also doing her time on the wards when I saw her; she'd been up all night and from the fourth floor of the Feldberg building spoke — very slowly, but eloquently, and a little wistfully — of her work "down there in BIAC." I met White after his Saturday shift in the Brigham's emergency ward, and we talked about career choices, alternative health care systems, and Plato over a beer in a Brigham Circle bar. There were a few basic questions I asked each of them — about their backgrounds, their experiences in the program, the futures they envision for themselves, the future of primary care medicine — but for the most part I just let them talk. They had plenty to say.

— David Bumke

Betsy Weiss

Senior resident, the Beth Israel

I have always thought that what I would enjoy about practicing medicine was just that: practicing medicine. You can get your kicks from medicine in a lot of different ways, but the thing that sustains me now, from day to day, when I'm tired and irritable and dragged out, is my relationship with patients. Some of it is solving the problems, some of it is the learning, and the excitement of the science. But the thing that really gets me through is all of that in relationship to the patients; and what it means to them; and how I deal with them. I think most of the people who want to do primary care need that, that's got to be where they get their motivation.

Most good medical schools, at the time I was applying for an internship, were still saying that a straight medicine program was best. You came out a better doctor, a smarter doctor, a more thoughtful doctor, a clearer thinking doctor. As I go on further and further in medicine it becomes clearer and clearer to me that that just isn't true.

Here, the internship year is not divided between straight medicine and primary care. By the end of that year

it was really important to me to confirm the fact that, yes indeed, I could finish this program and go practice medicine. Very few people seemed to be doing that, and I wanted to be around more people who were, who thought that was all right. So I decided on the BIAC program.

I've been blissfully happy. I love my clinic; you get a window into peoples' lives. When they come to you in times of crisis — which is what sickness usually is — people are much more open about many parts of themselves. That sense of thinking clearly about problems in the context of a

*"I think medicine is practiced
in a more humanistic way
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feeling."*

patient, a person, whose life you know something about, whose illness fits into a larger context than when you see them in a johnny in a hospital room — where they become a little less than a whole person, and more of an illness . . . I think I also learn medicine better, and think better about the science part, when I do it in the context of a person whom I'm responsible to.

When I watch Bob Lawrence, or Mark Aronson, or any of the other faculty people who work in BIAC, when they think about a problem with their patients, I can see how they approach it, how they gather what they need to make decisions about the problem. It's very rare when you're on the wards that people let you see what they don't know. When most of the time, well, there's just so much in medicine that you don't know. Everybody has to relearn it all the time, it's not static, you often forget as much as you learn in a day. But often the ambience of medicine is not that it's an ongoing process of acquiring and reacquiring knowledge, but that you reach some sublime level and then you know it all. And that then you just use your knowledge to make decisions.

There's a phrase people in BIAC use a lot: you have to learn to *tolerate ambiguity*. I think it's a good one. Most of the problems we deal with are not like a urinary tract infection that you fix with an antibiotic. It's somebody who shows up with a funny complaint in his shoulder; it's not clearly a full-blown bursitis, you're not sure whether there might have been some trauma to it. You have to watch it. They come back, and you see something develop and evolve. You can't function as a doctor for a lot of different people in a clinic and control everything.

Something like diabetes, when you see that in the hospital, you can fix up someone's blood sugar remarkably simply. But when you put that person out in real life where there are all kinds of other constraints — going to your mother-in-law's house every Sunday and eating everything your mother-in-law bakes, handling whatever the stresses in your particular life are — any medical problem is differ-



Partners on a BIAC team, Einhorn and Ann Murray, a nurse practitioner, pool their hands, minds, and tableside manners.

ent. Getting someone to take, and to understand why they need to take heart medicine four times a day on a regular basis, that's a different problem when it's outside of the hospital. And what that illness means, and how it affects that person's life, is different.

When I'm in Alaska next year, I'll be in a setting where I think — I hope, anyway — there is a different concept of illness, different from here, where illness is seen as so aberrant, rather than as part of a continuum of health, or of life; in the hospital, illness is something to be shunned and conquered and squashed. There you deal with a given problem in any number of major ways, thus upsetting all kinds of equilibriums. In intensive medical settings you find a very non-ecological view of life. There's not a sense that you're trying to maintain a person's homeostasis. Of course, most of the time people are there because they are really sick — their homeostasis is pretty well disrupted already. And in those cases it may be reasonable to act and react quickly and violently.

The Yeshe Dönden, who is the Dalai Lama's personal physician, was here today. It was very interesting to hear him talk about Tibetan medicine. One of the most striking things was the deep sense of humility that he had about his role as a physician. Clearly he had acquired a large body of knowledge — he said it's very hard to become a physician

in Tibet, you have to memorize many, many books. Everybody in the audience laughed. But he also said that there you view yourself as a servant of your patient. And you really share problems with the other health attendants — they're your equals. This is different from a lot of the ways western physicians deal with their patients at this point in time — and the way we deal with our fellow workers. That the patient is your partner in trying to heal, to control a disease, is something that isn't taught when you're on a medical ward.

Thomas Sterne

Intern, the Massachusetts General

When I wrote my application for medical school I said I think I'm going to end up a generalist, I like taking care of people, I believe in the care-taking function, not just the science function. Then, when I had to apply for a residency program I knew that I wanted training in general medicine. And I thought, well, if you want eventually to be some kind of practitioner for adults, you might as well learn how to take care of them in the office as well as in the hospital. Otherwise, you'll only learn how to take care of them in the office when you're finished, and it's just not the same thing. So I decided I would do primary care.

Every time I do an ambulatory rotation I feel a little bit more comfortable, like I'm learning a little bit more and doing a little bit better job. But in the beginning the experience is very anxiety-provoking. You can imagine, not knowing that much medicine, but coming out to where you have your own office, and all of a sudden there are three or four people trailing in during a three hour session, five or six people maybe, whom you've never met before, many of whom have charts as thick as a table is thick, who have had multiple problems in the past, who are on a lot of medicines, who have never seen you before either and who are in fact a little pissed off that their last doctor out in the clinic system was only there for twelve months, and now who's this new guy, and it's tough, it's hard. You think to yourself, oh no, the patient's in the office, I've got twenty minutes to figure out everything that's wrong with him, he'll walk out, he could have a heart attack when he hits the street, he could have this, that, or the other, and you've got to figure it all out right now.

You have to develop a sense of balance, and a little bit of a sense of timing. And you have to get to know your patients, so that you can tell when they're really sick and when they're at their baseline. That takes a long time. With each patient it almost always takes two or three visits. But as you grow, personally, you get a little less anxious. In addition to everything else, you realize that there are people around here to whom you can go for help. It's a little tough to run in and out of the office — okay, hold on, Mrs. Smith, I'm going to go check with another doctor — but you can learn how to do even that in a way that's comfortable for a patient, when you've exhausted your fund of knowledge and you think it's important that some decision be made before the patient leaves. Otherwise, you send them home and then just sit back and think about it.

When you have training in both economics and



MGH resident Dan Everett, right, conveys instructions to his Armenian patient via a translator, left.

"That your patient is your partner is trying to heal, to control a disease, is something that isn't taught when you're on a medical ward."

medicine you wear two hats. As a doctor, you have obligations to your individual patients that are in some sense inviolable. In addition to ethical obligations like confidentiality, you have an obligation to do the best possible for your individual patient. That's what they're there to see you for. But then you put on the cap of the economist, and suddenly you're looking more at the forest than at any one tree. And you say, well, do I really need to order all these tests, or this person, does he belong in an intensive care unit, he's going to die anyway, or the person is ninety-five . . . it's very hard. The best way you can bring it home to yourself is you say, well, what if it was your father, what if it was your mom, well, gee, Mass. General has twenty intensive care beds, and let's say they were all filled when your dad came in with a heart attack. Don't you wish then that there were twenty-one? But in point of fact, there are rationing decisions to be made all the time. There isn't an unlimited amount of money to be spent on health care — never was, you kind of fool yourself to think that there was — and somewhere along the line the society as a whole — based on the decisions of policy people or maybe to some extent the will of the population — has to make choices. Otherwise, for society as a whole, it's too expensive. For example, people on dialysis machines, their treatment is paid for by the government — and the costs have skyrocketed. You're obliged to do what you can for each indi-

vidual patient, given the technology we have, but boy, that thirty or forty thousand dollars per patient, per year — would it be better doing thirty or forty thousand vaccinations in the South Bronx? Or having a venereal disease control center? Or spending that on research? There aren't any clear answers; there certainly aren't any scientific answers. These are decisions based more on your politics and your ethics, your morality and your priorities.

When I try to look ahead to what kind of practice I might have, I have to remind myself that I don't have to do the same thing for my whole life. Lacking much in the way of subspecialty interests, I'm fairly sure I'll remain a generalist. And to the extent that I do have research interests, they are all in the areas I've been talking about, the planning and administrative and economic side of care, which in the long run may have as much to say about the kind of care people get as the science of medicine does. To be a full time primary care practitioner, to see patients for forty or fifty hours a week, every week, would be very draining. Even now, while I'm out here, I'm as tired, or more tired, than when I'm working in the hospital. I always have charts I haven't worked up yet, I go home but I'm always thinking about my patients, I'm always behind.

I'd like to practice in a rural setting, for a year or two, probably with the U.S. Public Health Service, or the National Health Service Corps. Then perhaps I'll work in some

kind of comprehensive, prepaid health plan, public or private, like the Harvard Community Health Plan, or the Health Insurance Plan of New York City, or the Kaiser plan in California. But even then, I don't think I could do it full time. I'm a generalist by nature. I have a lot of other things that I'd like to do; medicine isn't my whole life.

Ronald White

Junior resident, the Peter Bent Brigham

The Brigham's primary care program probably isn't typical of many programs across the country; there are such a high number of people here who go on to do subspecialty training. It's an interesting phenomenon. One motive for doing both primary care and subspecialty training is that you want to keep all of your options open. And you want to avoid boredom. No one wants to see nothing but sore throats, for instance. After ten years of sore throats it doesn't take an Einstein to figure out what to do about one. So people figure, well, I might get bored ten years down the road if I just see non-acute cases. So I'll keep the option of being able to work on very thorny problems, there would be an intellectual challenge to that, that's how I'll keep the vitality in my practice.

The way I choose to keep interested, to keep the challenges coming, is a little bit atypical, because I want to work on some issues that are not specifically medical. I'm interested in poor people, black people, and in how sociological issues impinge on the health of people in the community. I'm interested in how to work on these things, how to help people solve some of their life crises.

Mastering this phase of my life is involved with getting skills, mastering the machinery and the technology of medicine, learning some of the art, getting some experience under my belt. And then I'll go out into the community. Because I'd like to stay in Boston, it also seems like a very good idea to know the people in the hospitals — just from the referral point of view.

Being a junior resident takes so much time that I can't really put into practice all the things I've been thinking about. But I am currently helping to organize a training program, as well as counseling, at a church in Roxbury. We're taking people from the community who are pretty well put together, who have a job, a stable life, are doing okay, and training them in how to do counseling. Then we're going to refer people to them, people who aren't so well put together, who are having a difficult time organizing their lives, or even projecting any life goals, let alone pursuing them. I'm also organizing a lecture series on current health topics, to be given in the church by medical students. We're really just in phase one of these projects.

I see myself in the future as being what's called an "LMD," a local medical doctor. Working in the community, knowing people, being involved in a process where they participate in their own health care to the extent to which they can. With outside help when it's necessary. I think that's what, in a way, characterizes alternative health care systems. Not that I'm totally sold on one system as opposed

to the other. I want to take the best of both worlds. Of any and all worlds.

In the clinic there are already times when I can take things from my background and try them out. When I was in divinity school I taught meditation and a form of dance, Sufi dancing, that involves meditation. The other day I had a young lady, basically healthy, thirty years old, sort of a minor business executive. She said to me, "I don't know what the word 'relax' is." She's hypertensive, she was seeing me because her blood pressure is elevated; it's not a big league elevation, but it's elevated. So I gave her a meditation exercise. I don't know if that will control her blood pressure, and if it won't I'll have to move on to something else, to medication. I'm certainly not opposed to that. But first, we'll try meditation.

I think medicine is practiced in a more humanistic way than is generally thought — although every once in a while you get just the opposite feeling. Love and compassion are relevant dimensions in the whole doctor-patient relationship. Somehow this is never mentioned on the wards. Ever. Another issue that I never raise there is whether there is a spiritual dimension to human existence; and if so, what is its importance. And then also, if so, why is it never discussed. There are times when a person is dying, and you have some time, but that dimension of life is never discussed. Now maybe our world has become so subspecialized that the priest, or the minister, or the rabbi, they're the ones who are supposed to deal with spiritual issues. And doctors just talk about numbers.

These are only questions I'm raising. I really don't pretend to have the answers. Maybe there aren't any, but I try to be open-minded. I know many people, advocates of alternative health care systems, who think surgery, for instance, is anathema. You can't talk to them; everything is nutrition, everything is your diet. But I just don't believe it. First of all, they don't have any data. It's their opinion. But Plato thinks that's a very low form of knowledge. He specifically says, in *The Republic*, that opinion is a very low form of knowledge. You find close-mindedness on both sides. I just think it's very important to keep your mind open to all kinds of answers.

Earl Steinberg

Intern, the Massachusetts General

I had a number of reasons for choosing primary care medicine over a traditional straight medical track. For one thing, I had talked to several people in straight medicine, and it seemed that in most of their experiences the learning curve had plateaued by the third residency year. Once you'd seen your fiftieth MI, the marginal gain from seeing ten more was not likely to be the same as the marginal gain from seeing your first ten. In addition, these people really came out of their training experience without much background at all in a lot of other areas of medicine. In a regular program I wouldn't necessarily get exposed to many of the "specialty" clinics that we get in the primary care program, such as orthopedics, office gynecology, dermatology, ophthalmology. And clearly, when I was working in those

areas I would be on a very steep part of the learning curve. I thought that in primary care my overall experience would tend to be a broader one, and I hoped that I really wouldn't lose all that much on the inpatient elements. Now that people are doing three years in medicine, rather than just two, it seemed like there would be time to learn both parts. It's premature for me to say whether that rationale was correct; I'm still in my first year. But the people here in the third year of the primary care program tell me they don't feel a deficit at all. That's encouraging.

I have mixed feelings about whether the MGH program is the best way to do things. The first year of training is critical in terms of building your confidence for inpatient medicine. But the argument on the other side is that many of your habits get formed in your first year, and if you're not exposed to outpatient medicine in a setting that is really more conducive to enjoying it, you won't wind up going into primary care. The fact of having short stretches out in the primary care program — where you're not on call every third night — is a welcome relief from the exhausting schedule you endure as an intern. It gives you a chance to do more reading, and I think it helps put things in perspective. During those primary care stints you work one day of every weekend in the emergency room, just to keep your hand on the pulse of inpatient medicine. Probably the first year should be slanted heavily toward inpatient work, so that you don't come away in the very uncomfortable position — psychologically, at least — of being behind your peers in straight medicine. There's no feeling among the straight medicine people, none whatsoever that I have detected, that the primary care people are of any less quality. The people in the traditional track are sometimes a little envious, I think, that we're not always on call every third night, but there's no bitterness or disdain. In fact, several of them have expressed an interest in switching over to primary care.

The other principle factor that influenced my residency choice was my interest in health policy. It seemed to me there was much more room in primary care programs to do policy work; the people I spoke to in various programs were very geared towards health policy issues. Manpower issues, as well as other things. The five people the MGH picked for the program for my year all have had some sort of background in policy. It seems as if the hospital has made a deliberate decision to steer its program slightly in that direction. Another important thing about primary care for me was that it would provide a setting in which I could both practice medicine and participate in policy-making. There are very few role models for that — the policy people I met in Washington had given up practice, and vice versa. I can envision myself working in an academic setting where I would spend half of my time doing clinical work and half doing policy, either at a school of public health or someplace like the Kennedy school, or even consulting to the federal government.

I have not excluded the possibility of going into a subspecialty fellowship. I do feel very strongly that I would like to spend at least part time practicing medicine, but given my desire to do policy work, I almost certainly would not go into solo private practice. That's becoming less and less economically viable in any case, and I would just rather not be tied to a situation where I am the sole purveyor of care.

Celeste Robb-Nicholson

Junior resident, the Peter Bent Brigham

This is my first year in primary care, but it's my second year with my clinic population. As an intern I had clinic once a week; for me, at that time, clinic was very much the way it was for everybody else. Everybody hates clinic when they're so busy on the wards and have so many other pressures that they can't get to know the patients. I felt then that I was just kind of a history and physical machine. I was just a body doing the work. But now, in my second year with these patients, I know them as people. And I learn from them. I understand some of the reasons why they will or will not comply with particular medical practices. It's much more rewarding for me now than it was last year. Because when I learn from them I learn about life.

It's not simply that I see these people more now; it's also that I have a much more personal stake in finding answers for their problems. If you're on a private ward, the private doctor is the final arbiter of what is done for the patient. There I learn a certain amount intellectually, but it just doesn't compare at all to being that patient's doctor and having to make a decision. In the latter case I really have to decide what I know, and what I need to know. In primary care, because I see more patients that are "my patients," that I have to make the decisions for, whose treatment plan I have to come up with, I spend more of my time finding out for myself what the best management for something is — rather than learning from Dr. X the way he or she has decided to handle a patient, and then just carrying out that plan.

We always think we need supervision on the inpatient service where the patients are very sick; we think we need the experts to tell us how to do things. But it also takes an expert to know what can wander around on the streets, it takes an expert to know what the course of a disease process will be, what things to watch out for, what things to worry about, what things to let ride, how to get the patient to tell you why they are there. It's not automatic. Primary care doesn't teach you brand new things about patients; it doesn't bring new, earth-shattering ideas to mind. It just gives you a chance to learn from people who've been in outpatient practice and who understand outpatient management. You get to "learn by doing," in a well-supervised environment.

There's just so much you can get out of doing inpatient medicine all the time. In primary care, as residents, we get a year's worth of that, spread out over two years. And then we do the outpatient work. We spend every other four to five weeks in clinic rotations, where in the mornings, Monday through Thursday, we see patients in the clinic; in the afternoons we do specialty rotations: gyn, GI, dermatology. For example, I see patients with a psychiatrist once a week. I'm learning some of those skills to incorporate into my office practice. Those things aren't automatic. People who are trained in medicine aren't trained how to listen. That takes a lot of time and a good observer to teach you how. But it's a very important skill to have.

The other thing about primary care training is that it gives you a little more time to live your own life. And I do believe that living and experiencing your own life makes

you better able to understand what your patients go through. If you're spending all your life working very, very hard in the hospital, so that events don't touch you, the news never touches you, family life hardly touches you — well, drumming feelings out of yourself does not make you a better doctor. It really doesn't. It makes you much less able to appreciate the effects of your therapies on the patients' lives. You know, we can do all kinds of things to manipulate their biochemistry, and their limbs, and their organs, but if what we're doing really and truly is going to destroy their home situation, or not enhance it, then I don't think we're helping to meet their needs. We're just meeting our own needs, our needs to see things happen. But it's very hard to appreciate that difference unless you have an investment in life yourself.

Because I hope to have a family, and to do a number of other things in my life, I will probably always be a part-time practitioner. I don't know now exactly what the context or setting of my practice will be, but I know it will include day to day patient care. And I would like to have admitting privileges, so that I could follow my patients into the hospital. Above and beyond these basic requirements, it would also be delightful to have students around, or to be involved in teaching residents. That would enhance my own habits. Having to discuss my own patient care with another person, to teach that person, would continually force me to re-examine my own standards.

Daniel Einhorn

Junior resident, the Beth Israel

I'm not offended by a patient coming to me, an internist, with a psychiatric problem. That's a perfectly legitimate reason to come to a physician. In fact, whenever someone comes in with any chronic disease, I think that in order to be a good physician for that person one must take into account several things that are not strictly medical. The patient may not have what a psychiatrist would call a formal psychiatric syndrome, one that would require psychotherapy, or psychotropic medications, but he does have a certain character, he has a certain psychosocial context, a certain economic class, a certain set of expectations, a belief system, a set of hopes. Even when an illness is poorly defined, even when it doesn't seem to have a clear psychiatric or medical basis, it's still a person in trouble for some reason who has decided to come to a physician. We have no small group of people here who are in that category. We're not sure what they have. But they're troubled people. And so we see if we can make some difference in their lives.

There are some patients who won't allow the kind of joint operation with a physician that makes things so much easier. They come in with the statement: Now you take care of me. Such people really present problems to the system. Sometimes in private practice they are subtly turned away — because to manage them requires, one, some support. You need to have your colleagues there to let you know, gee, it's good that you're taking care of this man, we know how difficult it is. In addition, you need an intellectual framework in which you can say, this is a worthwhile function of mine, this is an interesting illness, look, this person

has this demanding character, for some reason, look at what he's putting me through. You need the understanding that this kind of a problem can be as interesting as, for instance, an abnormal cardiogram.

Probably the word "respect" is about the most on-target one I can think of in terms of the way the doctor handles any patient. It means respecting all of the different things about a person, not just his interesting skin, her abnormal blood test. There are people who think of the medical model as really a consumer model. Consumers come to us as clients, and we are vendors, of a service. I have trouble seeing it that way; no one who sells me an air conditioner feels toward me the way I feel toward my patients. But what that model would mean is that patients are expecting us to treat them as people. It seems bizarre to have that even be brought up as an issue, but maybe in the past patients haven't been treated as people often enough. With the increase in technology in medicine there are many specialties where one can completely disappear from human contact, and yet have a lot of input into a patient's medical care.

Most of us have been taught in medical school to have as role models physicians who never mention the fact that taking care of a patient is much more complex than working up someone's cardiac erythremia. I'm not saying that every cardiologist who comes to teach a medical school class ought to talk about the patient relationship — because, after all, you've also got to learn cardiology. But I think by and large most of us came out of a system that had essentially forgotten the person — and it's really fun, in my training here, just to have the person back.

Primary care, though, is still the black sheep of the medical family. Medicine needs to see itself as a very specialized system; it takes a lot of time and energy to get this really unique kind of expertise, to be able to do dialysis, for example. Anybody can talk to another person, and the system may ask itself, well, how much will you reward physicians for spending time doing what someone who has never gone to medical school at all might do equally well. And my only argument to that is that it doesn't take any more time, in outpatient medicine, to talk to somebody. It's just the way you conduct your practice. In my own practice I've seen that it can help keep people out of the hospital, help to cut down on the number of visits. Some of my patients have my home phone number. They never use it; they just know it's there. And I think that the very fact that they have it helps them not need it. They know I'll extend myself for them. I've seen some other people who absolutely refuse to give their patients any way to contact them. And those patients call back. They feel at loose ends. What's going to happen if I need somebody, I have a pain in my chest, I don't know the doctor's phone number — and this sets a whole chain of things in motion.

When I choose my physician, I choose someone I think is competent to take care of me — and I'm generally not thinking in psychological terms. When I have a pain in my leg I'm not thinking "me as a person;" I'm thinking "pain in the leg." I want someone who knows how to take care of my leg. That's number one. In a sense, anything beyond that may represent gravy. I just think it's very important gravy.

The Doctor-as-Patient

An interview of Robert Coles by George Abbott White

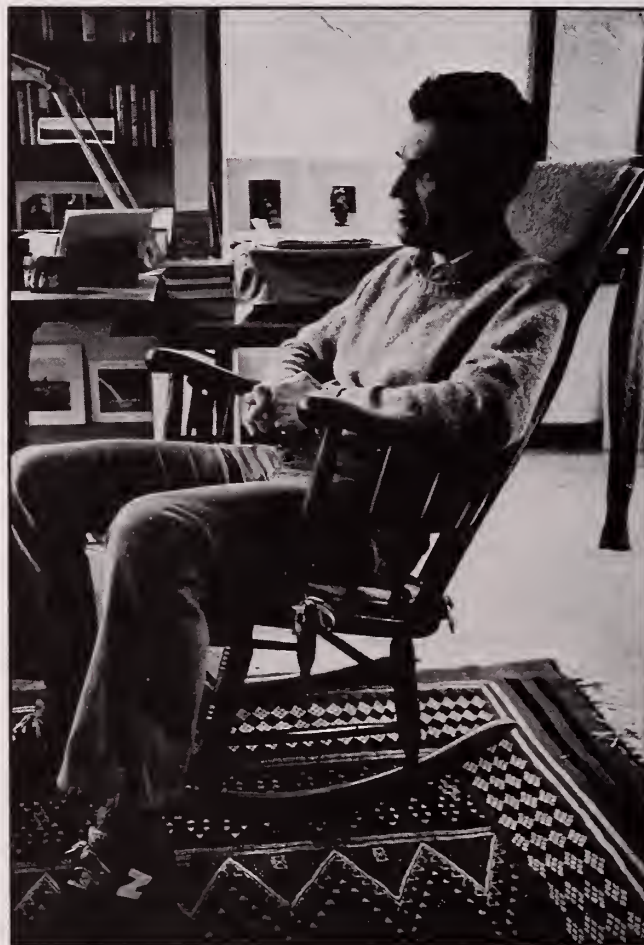
What do you mean by the doctor-as-patient? First of all, the doctor as one who is patient; patient in the Latin sense of *pator*: able to respond to suffering, feeling the suffering within oneself, long-suffering in the old-fashioned sense of being willing to ride out the ups and downs of illness with patients and, inevitably, becoming part of that process. I believe that is what Christ meant, when He said, 'Physician heal thyself.' After all, long before the concept of counter-transference, Socrates in his way (with his stress upon our knowing ourselves) and Christ in a more affective way (insisting that we tend to ourselves, hear ourselves) had become part of Western culture, long before a Viennese physician in the late nineteenth century started paying attention to his dreams.

Freud is a good example of the doctor-as-patient; I know of no better one since St. Augustine. Freud had the gall to feel that if he paid enough attention to the tempest and turmoil and anguish of his own mind, he could learn from it and through that learning, be healed himself, and through that healing, reach out to others in need. St. Augustine and then Soren Kierkegaard are the high points in a tradition of subjectivity in Western intellectual life, and also in Western medicine. This tradition reaches back to the Greeks and to the Hebrew prophets.

When we speak about the subjective dimension, we are speaking about symptoms, yet modern medicine stresses signs.

If I may use a psychiatric term, ironically, the life of the mind is always in danger of "splitting." Not only patients split — separating affect from object — but intellectuals as well. Why we would want to place on a scale pain that is measured by our instruments as against pain that is felt by another human being is an example. Making this a matter of good or bad, better or worse, something that deserves our attention and something that does not, is our kind of split, our kind of judgment, and one connected to certain intellectual and class notions of value. It may well be that we, as upper-middle class scientists who have a vested interest in the measurable, will only allow for the measurable in our working lives. People come to us with all kinds

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“Suffering enables vision; it enables perspective and detachment in the most useful sense of those words. This is what we can learn from our patients, and from our own patienthood.”

of symptoms which we do not care to dignify with one of our labels or call just. Why? Because their symptoms are not measurable. This tells us as much about our education and our training as about our patients.

It has been said that doctors, as a rule, are poor patients.

I can't agree; it would depend upon the particular doctor. One who taught me medicine when I was in school was an extraordinary person and, ultimately, an extraordinary patient. He was a kind and thoughtful person whose humanity persisted to his dying day. I would not want to generalize by vocational or intellectual interests. I can imagine a future medical student taking a great many English courses, art courses and music courses, and being as arrogant and cold and mean-spirited — and as unaware about himself or herself — as the student who studies what, these days, are regarded as the unfeeling and aloof disciplines, say, engineering or statistics. This is because the humanities also generate highly-abstract responses in those who study them. The issue is not the courses, the issue is how the individual puts them together in his or her education, and then how all of it is put together in his or her life.

How do you feel as a patient?

Vulnerable . . . as we, who are patients, all do. Vulnerable and wishing that we weren't. I do not feel I have any special defenses against this because I have been trained in medicine, however. I think that goes out the window very quickly. Once in that office, one is just hoping against hope that everything is going to come out well.

A physician with cardiovascular illness once wrote, "The patient needs more than treatment and reassurance, he wants his physician to take the responsibility upon himself."

Well, I think the responsibility or weight ought to be a shared weight. It should never be solely on the patient or the physician. It's a hard job to be a doctor, to assume these matters of life and death as day-to-day obligations. The wear is great, and to be cast as the antagonist of an inevitably victorious Death is to assume a Promethean burden. For those who believe death can be "beaten," that's one thing, but for most of us it has simply been pushed back. The struggle remains. We want that struggle to take place, and we all hope that the outcome will be as victorious as possible, giving as much time as can be had on this earth. That sounds sinful — if you want to use religious imagery — but it is also terribly human to want that time.

In this shared experience, doctors and patients have duties towards one another. That is what the French philosopher Simone Weil meant with her discussions of *affliction* and what one learns through affliction — both while experiencing it, and while understanding the affliction of others, say, physicians. After all, doctors are afflicted in bearing these serious burdens occupationally. Engaged with the hurts of the world, they are in a unique position, however, to learn from themselves and from their patients. Whether they take advantage of that, whether they are trained to take advantage of that, is another matter.

Isn't the doctor's role to prevent suffering?

Prevent, yes; avoid, no. Simone Weil said that while one does not want to search suffering out and embrace it, on the other hand, one doesn't in the course of one's life try to pretend it doesn't exist by avoidance or denial. In the ancient languages this was known; that is why *patiens* (suf-

fering) is connected with *sapientia* (wisdom) — so that patience is one of the prime attributes of wisdom. Suffering enables vision; it enables perspective and detachment in the most useful sense of those words. It is peace and thoughtfulness, and a kind of quiet reflection. This is what we can learn from our patients, and from our own patienthood.

The doctors of doctors, don't they assume that their patients already know what is to be done?

I doubt that it matters because the doctor-as-patient is always a human being who, through language, is asking the peculiar questions that human beings have asked throughout history, namely, what am I about and what is this sickness about? Where am I going, how long will I be here, and under what circumstances? These are the questions that our friend and physician, the novelist Walker Percy, reminds us are the ultimate questions that human beings — and only human beings — know to ask.

I know there are a number of doctors in his novels.

Oh yes. In *The Moviegoer* there is Binx Bolling, the future medical student who is also the son of a surgeon, the grandson of a surgeon. Dr. Vaught is in *The Last Gentleman*, and a number of scenes there, too, take place in a hospital. We meet Dr. Moore in *Love in the Ruins*, and in *Lancelot*, you may remember, the entire novel takes place in a psychiatric hospital. Percy has worked all manner of illness and medicine into all four of his novels. He has drawn upon certain prior characterizations of the doctor, most notably those in Albert Camus's novels, where physical illness comes to stand for kinds of ethical and spiritual illnesses. Like Camus, Percy sees the doctor as inevitably in an existential situation, that insofar as he is dealing with one of the most fundamental aspects of human existence — sickness and suffering — and the questions connected to both of them, the doctor is in a special position in terms of his own life as well as in terms of the lives of others.

Percy is a physician — a pathologist — who has become a metaphysician. The connections between the two are just as direct and as continuous as those two words imply. Metaphysics pushes medicine just a bit further. Anyone who becomes a physician ought to understand that connection and become aware of the metaphysicians, whether they are the Greek philosophers, whether they are the novelists-philosophers such as Dostoevsky, Tolstoy, George Eliot, Charles Dickens, or whether they are the philosophical writers of our century, Bernanos, Percy, William Carlos Williams or Simone Weil (who knew what it was to suffer personally, and to make of that suffering a philosophical quest). She had a father who was a physician, she knew how the physician has been buried in the material world, how people have denied to him and to themselves the dialectic between the material world and speculations about it: that connection between the specifics of illness and the mind's efforts to come to terms with what that illness means. She took seriously the fact that all of us will die — that is, she saw how that fact bears down upon our daily lives, no matter how "healthy" we are.

The writers you have mentioned criticize the doctor, but also seem always to find something to praise.

Certainly, because that mix exists in the world. I have come into contact with a great many doctors and in situations that are not conventional, because I do most of my work in homes. I have been visiting homes for the past

twenty years, and some of them have been physicians' homes where you do see both sides of the coin, and often without apology. Look, physicians are trained to have a sense of importance and authority that opens them up to criticism, they experience this all the time at the hands of their patients. That the self-importance gets out of hand is an occupational hazard, the result of being treated like gods and of allowing ourselves to be treated like gods.

There needs to be some systematic way, in the course of our education and in our continuing education, to deal with that issue — both in our own lives and in the lives of our patients. This temptation is daily (the religious call it a terrible sin), and we do assume god-like prerogatives, but it isn't only our fault. It is obviously also the fault of those who are vesting us with it, and of a culture that supports both the giving and the taking. As Freud cautioned, there ought to be a self-critical process at work to deal with this kind of illusion of control and power, an illusion that becomes, for us, a dangerous delusion at times: a usurpation of reality. It needs undercutting. In analysis, of course, one continually undercuts by interpretation and self-interpretation. How analysis might deal with another aspect of this problem, I wonder — namely the social and cultural forces that elevate doctors so high. I mean, doctors are reasonably well-to-do people who have a privileged position within a particular economic system and a secular world. (This is insofar as money brings privilege.) We have a moral authority amongst the general public that seems to grow from that privilege, and from a widespread agnosticism. But being on that kind of a pedestal doesn't help our self-awareness and our self-critical faculties.

Have you encountered physicians who have this kind of self-awareness, perhaps as a result of their patienthood?

Yes, but more in rural parts of this country. I think of several I have met, one in eastern Kentucky, and one in the northern part of New Mexico. They were astonishing, though we might easily dismiss them as old-fashioned country doctors. They were themselves badly ailing, old, obviously dying men, but each worked very hard, and was of enormous significance to the people and the patients they attended. I know they did lack for some contemporary medical information, but I will tell you that under those circumstances, when it was either those doctors or nothing, it was better to have them. And I also know, having gone with them on their rounds, those doctors were doing, day-to-day, not only the Lord's work, or Hippocrates's work, but they were doing good medicine in home after home. Thinking about them now, it is clear to me that in certain cases, limitation forces us back upon earlier parts of our medical training we slighted or forgot. I remember a blind pediatrician in West Virginia, blinded by an accident in mid-career, who still continued his practice in a wonderful way, but by going back: he was listening as he never listened before, he was always listening. His histories were particularly detailed, his examinations extremely thorough. But this was only what Anna Freud pointed out years ago as what the blind do: they learn other ways of coming to terms with the world so that very little is lost.

You once said the same of Dr. William Carlos Williams, that he had a passion for all experience, that his poetry was so packed with the particularity of his experience that there was no room for abstraction.

Dr. Williams's expression was, "No ideas but in things." And he is very important for us on just these issues, primary care physician that he was. If you read his *Autobiography* and the last volume of that epic poem of his, *Paterson*, you will see the doctor-as-patient, and all that he learned from being that, most vividly. The last volume, incidentally, was written after he had had a heart attack and several serious strokes. He knew he was dying, and had gone through a severe depression.

I knew Dr. Williams from 1949 on. I wrote my undergraduate thesis at Harvard on him, and visited him repeatedly when I was in medical school at Columbia Physicians and Surgeons. I went on rounds with Dr. Williams and saw that he was a doctor while he was a patient, while he was ailing. He was born in 1883 and died in 1963, but for the last fifteen of his eighty years he was in serious trouble. Nevertheless, the tie to his patients remained strong. He once said to me, "I feed off my patients." Those who have written about him "stealing" time for medicine from the poetry or the fiction have gotten it wrong. It was entirely the other way: the medicine "fed" the poetry, and Williams said it himself in print many times — in his poetry, his *Autobiography*, his short stories. Literary critics make this error because they are preoccupied with the poet as a full-time writer, which is what many of them have been. Williams was not, could not be that kind of person.

He loved those visits to the home. And by the way, the physician-as-writer in Williams merges with the physician-as-patient, because if you look at those doctor stories in *Life Along the Passaic* you immediately notice that he is writing, not only about the patients that he was treating, but he is also writing about the doctor: the doctor who is ailing, angry, impatient, confused, tired. The doctor who hurts and who wonders why, at times, he ever became a doctor — partly because of the patients he is treating, partly because of all those other interests, like the writing of poetry, the love of art, the concern with politics. The tension here is between the doctor-as-sufferer who is *also* the doctor-as-healer. Emotions, we see, are used to the good rather than used self-destructively. Williams in these doctor stories, in *Paterson*, in the novel *White Mule* is thus the self-aware doctor who can go on to worry about how people struggle when they give birth to children, when they later bring them up.

Yet there is the other side. We see the doctor who is distrusted and even feared.

Yes, and why not? He brings the "bad news" and he knows more than one wants him to know. And yet he knows what one has to know. This is a paradox we all struggle with and it is never going to be resolved. We are simply going to have to learn how to live with it. There is a kind of blasphemy in wanting to know too much and yet it is also in our nature to want someone to know too much. And as good doctors, nothing less than everything is enough in order to do our job well. So we do want to know everything, and yet have to learn how to use what we know with discretion — which means filing some of what we know, not mentioning some of what we know, using our knowledge indirectly, tactfully, sensitively. And at the proper time, and for the proper amount of time. There is a great deal of the subjective here that must be handled with discipline and discretion. Discretion is essential for physi-

cians because lives are at stake, sensibilities in jeopardy.

How would you say Dr. Williams used what he learned?

I would go with him from home to home in Paterson, New Jersey, where he was well known in what we would now call the “ethnic enclaves.” He was known to the Greeks, the Poles, the Blacks, the Jews and to the last remnant of working class Protestant whites of New Jersey who hadn’t escaped north to New York, or south to the suburban or more rural parts of that state. They were all people hard pressed or stuck and they were all his. They worked in the factories and in the shops and the stores. They were blue collar and poor white collar who had an entire range of occupational illnesses, daily injuries, colds, flu and alcohol problems. He went up and down the stairs in tenements constantly, and I will tell you what he did: he had a pad of paper in his car. He’d leave the pad there, he would go into the homes, do his doctoring, come back to the car, and he’d write the lines down. At least I think that is what he usually did, because when I was with him he’d come back and say, *Did you hear that? Did you hear what she said?* And he’d be writing it down, whether I had heard it or not.

For whom? For some future audience and for himself, first, because he was the audience, after all, listening. And then for the others who would listen through him, because he was their intermediary. This was the poetry, this was the fiction which he went out the door with — as he once put it, “I stole those lines from all my patients.” And then he would give those lines a structure which, of course, one has to acknowledge. (It wasn’t as if the lines just fell into place, you know. The worst of oral history, just like the worst of case history, is taking all this *stuff* and not knowing how to edit it so that it makes sense to a reader. Much of what passes for an “accurate account” is not only entirely ignorant of context, but utterly lacking in effective organization, the kind of honest, simple elegance that Williams gave to his published work.) Then the poet — Williams — added to it. In his writing we see the lines that he heard, but also the lines that he created.

People make mistakes by drawing distinctions too arbitrarily. Polarities like subjective-objective or physician-patient, for example. There is Williams-the-doctor who hears lines and then puts them into poetry, and here is Williams-the-poet sitting in his study listening to himself, and then making a poem out of that. Selves merge, and never more so than in Dr. Williams’ case. But then I suspect they merge in every writer’s life — every person’s life. If you were to talk with a novelist like Walker Percy or Robert Penn Warren, a poet like Williams or Muriel Rukeyser, you would find out that what they were doing was — to use a phrase that Simone Weil favored — *paying attention*. (She once said that attention is the rarest and purest form of generosity.) They were listening to the world, in the world: listening in shops and grocery stores, in department stores and while teaching, during a visit with a friend or a neighbor or overhearing a chance conversation on the street. All those impressions, all the language that washes over, they then through the genius of the creative personality, filter into stories or poems. They filter the outside world through their inside world, but there is not this sharp distinction between the two, as though they are up there in an attic disconnected from the world. The world filters through the lives they live just as it filters through ours.

How would you relate your work with the medical humanities program to what you have just said?

Through the novels and the poetry and the short stories, I try to bring alive situations I believe doctors are going to experience. With Williams or George Eliot, one is up against the problem of the healer who, himself or herself, is desperately ailing. (What recurs in Williams is the doctor who finds himself annoyed with the very people he wants so to help, and who often feels badly that he is annoyed.) The beauty of this fiction is that it brings the reader almost unbearably close to the heart of the matter and yet, keeps a distance from it. The doctor-reader can draw upon fictional situations as though they were life, but, of course, the imagination has transformed them so that, in the act of reading, we get not the thing itself, but the *experience* of the thing. I know of no other medium that will enable us to have it both ways, so close to reality and yet at an edifying distance. One comes away with particularity rather than abstractions, with the memory of particular characters — in all their complexity — rather than the overwrought generalities that all too often pass for social science.

I have a feeling that doctors are the least cared for, least cared about.

I have not seen that studied, although I have to agree it certainly should be. We do know that doctors are subject to a fairly high rate of serious psychiatric illness, perhaps because they are under enormous pressures. Some would say that of those who go into medicine, a significant number are those who have known hurt and pain, who are trying to find a place where that past experience will be meaningful. I don’t know. One has to be careful about such sweeping statements, especially since so much unfairness is directed towards physicians. Medicine is likely the most studied profession of all, overstudied perhaps, and yet so little attention is paid to the doctor’s needs.

By comparison, what do we know about the people who go into business or law? Very little, I’m sure. We tend to know more about doctors, and considering the gap in our knowledge of the doctor-as-patient, perhaps far too much is made of what is known. The nature of their work encourages doctors to open themselves to the interests of others, to become vulnerable as an occasion for self-awareness, learning and growth. In my own work I have seen how much easier it is to observe the staff of a teaching hospital throughout a day, those in an emergency ward or clinic, than it is to walk into the offices of a major law firm, or the conference rooms of one or another leader in a major industry. These research limitations have their parallels, I should add, in the fact that it is all too easy to study the poor and the dispossessed rather than the wealthy and the powerful. Aren’t these latter much better defended against the inquiry — if not the inquisitions — of social scientists? And aren’t social scientists oddly reluctant to press forward in those cases? The point is, in spite of all the apparatus of modern social science inquiry, we know less about doctor’s illnesses than about the illnesses of the countless special interest groups to which doctors minister. A change here, however, would require doctors to take themselves seriously in the ways we have been discussing — stand up for themselves, remind themselves of their special vulnerabilities, but also their social responsibilities and yes, the wonderful opportunities they have.

by Lucy Candib

The Family Practice Visit

Coming to a personal style

The other day I was listening to a patient's heart. She was sitting up. As I moved my stethoscope on her chest with my right hand, I noticed for the first time what my left hand was doing. It was holding her right shoulder firmly — like a rock. Since then, I have wondered: What do other clinicians do with that free hand? Do they dangle it, or rest it on the exam table? Do they lay it lightly on the patient's shoulder, or do they — as I do — hold onto the shoulder steadily? Other questions arise. How far from the examining table do I stand? Do I close my eyes to listen to heart sounds? Do I do the same things with different patients? And what sense does each of these possible actions convey to the patient? Observing myself and my colleagues, I became more aware of the elements of our non-verbal behavior with patients. Our routine patterns reflect both conscious and unconscious feelings derived from our own psychological and social experiences. Thinking about these issues, I reflected on my own personal preference to work in close contact

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with patients — to be a maximum of perhaps eighteen inches away, when we are both sitting down. But the fact that this is a comfortable distance for me does not necessarily mean that it will also suit the needs of a particular patient. Therefore, I need to understand not only why I choose a close interpersonal working distance, but also to recognize those groups of patients with whom I work easily and others with whom I am likely to have difficulties.

Coming out of a Freudian tradition, I realize that my habit of preferring to be close to a patient emerges from the unconscious issues of childhood. For myself, I acknowledge that my deepest fear as a child was of abandonment. I developed a protective habit of moving close to people and building tight relationships to prevent being deserted. The habits of childhood have lingered long after the issues have been resolved. In my work the results of these persistent behaviors are predictable. I have a loyal group of patients who, according to the receptionists, refuse to see other doctors. And I feel a great deal of stress when I break away for a vacation. I suspect that I worry that the patients will feel abandoned.

People who often feel frightened or trapped may be particularly uncomfortable with my personal style. With this in mind, I can sometimes make a conscious effort to alter my routine behavior. Recently, a male resident asked me to check an abdominal exam on a woman. When I walked in, she blurted out, "Oh, no. A woman doctor. I hate women doctors." I certainly hadn't expected that kind of reception. But unusual situations call for unusual responses. The room was small, eight feet by eleven. I deliberately stationed myself in a corner, as far from the examining table as possible. For a few minutes we chatted about the patient's work as a school administrative aide. Only after a time did I ask her if she thought I could come over to the table and touch her stomach. She assented. The exam was unremarkable. I suspected that she had been tense for the resident's exam, which made his evaluation difficult. Later he told me that she had confided to him that I was the first woman doctor she had ever liked.

Three things seem worth noting here. First, my customary behavior

would have frightened this woman. Second, she herself gave me the signal not to come too close. And finally, the unusual quality of her reaction to me alerted me to alter my standard style in order to examine her. While some observers might have noticed that the patient seemed generally suspicious, the resident couldn't have known that a woman doctor would elicit such extreme negative feelings from her. If she hadn't warned me herself, I would no doubt have overwhelmed her with what for me would have been only an average degree of closeness. Perhaps closeness had been a problem in her previous interactions with women physicians.

The success of particular strategies of physical interaction also depends on the age of the patient. For instance, infants, young children, and adolescents have differing developmental responses to closeness. Watching myself interact with babies as they grew in the first two years, I became aware that I was not faring well with toddlers fifteen months and older. Small infants were easy to engage; they liked to be touched and held. But with toddlers, office visits frequently deteriorated into tearful struggles. I concluded at first that this was just "a terrible time" and that *they* would outgrow it. I started to see things differently one day when I was examining a one year old whom I had delivered. I recognized the baby as someone I had known for more than a year, who had grown since the last visit. Yet I was startled to realize that this relationship was not reciprocal. I felt that I knew the child, but the child considered me a stranger. I then recalled watching an experienced senior pediatrician consult on an infant of about a year. He had entered the room and seated himself at what seemed to me an unusual distance from the child — until I understood that he was quite automatically anticipating the response of a child that age. What I had forgotten was that after three months I am a stranger to a toddler, despite my personal history with the parents and with the child's birth and infancy. I wanted to pick up this big-eyed baby for whom I felt an attachment, only to find out that the baby was scared of me — as she would be of any stranger.

As a result of this new-found understanding, I now practice keeping

my distance with toddlers. One method which has worked well for the child and for me is to use a large teddy bear as a routine part of the exam. The bear sits on my lap and gets the stethoscope applied to it for a few moments while the child watches. Then for three or four seconds I can apply the stethoscope to the child before he or she starts to cry. Then back to the bear. I repeat the same process with the ears. This anticipates by several years the use of a real "projective" method of health teaching with children, when their ability to tell stories and rehearse medical events can be used to allay fears. In addition, holding the teddy bear satisfies for me the desire to express the warm feelings I have for a child I have been following for a year or more.

As I continued to examine my personal style, other patterns fell into place. On occasion I have found it hard to get young teenagers to talk. Again I attributed this to their age. But when I looked at my style, I found that I was making things worse. An integral part of my approach is plenty of eye contact. We even evaluate residents according to how much eye contact they maintain with their patients. However, it has only recently occurred to me that what I consider an average amount of eye contact may be perceived by a shy, uncertain adolescent as pushy, pressured, and uncomfortable. Lately I have been taking pains *not* to look at teenagers when they act shy, limiting myself to intermittent glances for affirmation that we are talking with each other.

Although I have been talking mostly about the problems, my preferred style also creates unexpected benefits. I work in a neighborhood health center where a third to one half of the patients are Puerto Rican. Despite the fact that my Spanish was not fluent when I first went to work there, I was very warmly received by Puerto Rican patients and am sometimes asked for as the *doctora* who is *Hispana*. My success was originally as much a mystery to me as the difficulties cited earlier. But with time, I realized that my non-verbal behavior is intrinsically compatible with the behavioral styles of Puerto Rican people. Researchers have found that in the use of body space, Puerto Ricans are comfortable with a personal distance of six to eigh-

teen inches, whereas North Americans are likely to be more at ease at eighteen to twenty-four inches — reserving closer distances for intimate relationships. Consequently I am well accepted when other equally competent and concerned clinicians may be considered distant and cold.

In psychiatry, the trainee classically has been taught physical neutrality. The Freudians insist on the avoidance of any physical contact whatsoever. One example of the success of this approach was related to me by the analytically trained consultant psychologist at our health center. He had seen a woman patient for nine visits before she took her coat off. On each occasion he had staved off the gentlemanly impulse to help her remove her coat. On the tenth visit, when she finally did take it off, she admitted to him that she would have stopped treatment if he had tried to assist her, because in her work as a model she felt that men were constantly trying to disrobe her. However, neutrality, when it is carried to an excessive degree, may undermine a patient's treatment. I know one psychiatrist who seats patients opposite her across a round coffee table five feet

in diameter; to me this arrangement seems chilling and remote.

As a family doctor, I do not have the choice of physical neutrality; an integral, crucial part of my work involves touching patients. Yet the principle of attention to the style and quality of physical interaction must be applied in our discipline as well. Some clinicians may maintain that they already alter their style and method for individual patients. However, as Byrne and Long have shown (*Doctors Talking to Patients*, London, 1976), even doctors who believed that they varied their verbal styles depending on the individual patient actually used only one principal style. My hunch is that most clinicians likewise practice in a preferred non-verbal style, without much attention to the consequences of their behavior. As family doctors, we should attempt to identify our personal styles and their origins and to become familiar with the benefits and drawbacks of our particular clinical stances. We then will be able to improve the quality of our work with patients by deliberately, and with self-awareness, changing how we respond in the unique encounters that make up family practice.

Doctors Interfere

*Doctors interfere
and so they should.
If nature took its course,
Barbara would be dead,
her child landlocked.*

*Sometimes too much:
We bound too tight
and bled and purged.
X-rays for the acne.
Thalidomide? Young Bride.*

*Sometimes not enough:
Humpybacks will unsway,
growing pains go away.
Failing to seek,
we did not find.*

*We're cleverer now,
mistakes of generations
slowly learnt.
But what are ours?
I think (but cannot cast the first stone)
we have forgotten
medicine is an imperfect art,
its science inexact
and deluded with good intent
that we have the talisman
for pain, grief and death.*

*Check-up
your heart, your guts
lungs and breasts.
Check-up
Check-up
and be spared,
which may be true
and maybe not,
I only know there is no life
free of pain, grief and death.*

*And there is a cost
of feeding into fear.
We have become part
of this childlike pout
for perfection,
denying death
and life.*

— Hamish Gillies



Arthur Rothstein: Reedsville, West Virginia

by George Abbott White

Primary Care in the 1930s

Working people
consulting the doctor

Some neglected photographs from the Depression years have become useful reminders of the roots of primary care medicine.

Between 1935 and 1942, a handful of photographers with the Farm Security Administration (FSA) compiled almost a quarter of a million images of the United States, taken in every part of the land. A small fraction of these, two thousand or so, illuminate commonplace medical encounters: doctors and patients together. These FSA medical photographs are unique in two respects. First, as a part of the entire FSA photographic effort they are linked to the most comprehensive series of documentary photographs ever made. And within the category of medical photography, they are unique because for the first time, photographs show doctors and patients together, not in dramatic encounters, but in mundane, everyday medical practice away from the hospital. The photographs reproduced on these pages are from the FSA medical photographs, and from the exhibition of

The photographs for the exhibition were selected from the FSA collection in the Library of Congress. First mounted in 1979 at the MGH, the exhibition has since been shown at the Countway Library of Medicine, HMS, and Eliot House, Harvard College, and is presently on display at the Baylor College of Medicine in Houston. Inquiries about the loan of the pictures should be directed to George Abbott White at Eliot House.

fifty-six of them that has been mounted as a joint effort between HMS, MGH, and Eliot House, Harvard College.

History of the Photographs: FDR, AAA, RA, FSA

The FSA, one of FDR's experimental alphabet agencies, had two direct New Deal predecessors. One, the Resettlement Administration (RA), was a catchall organization intended to compensate for some "important miscalculations" in the other, the Agricultural Adjustment Act (AAA). The AAA had worked well for large, firmly-established farmers, but it also had had the effect of squeezing out middle and low-income ones. RA programs, which began in 1935, reached those in the middle income, yet millions of renting and tenant farmers continued to be displaced until 1937, when the RA became the more inclusive FSA. Direct loans from this latter agency saved innumerable small farms, while its innovative social service programs provided rural sanitation and developed badly-needed housing and health facilities for those who had been displaced: migrants and their families. FSA programs included, significantly, a prepaid medical plan of office care by general practitioners for recipients of FSA loans.

The FSA photographs originated in the Historical Section of the FSA's Information Division; they were taken under the direction of that section's extraordinary head, Roy Emerson Stryker, who was both prop

and prod to his photographers. The FSA was constrained to continually justify its programs before Congress, and this, in turn, led to a seeming contradiction in the kinds of images the Historical Section pursued in the field.

On the one hand, the FSA photographers identified previously-ignored social evils which Roosevelt's administration was at pains to programmatically correct. The conditions of the dispossessed required images that would condemn. But it was not enough simply to record the worn-out land or the horrendous living conditions. FSA cameras also had to focus upon FSA programs that could work, and later in the 1930s, the ones that were in fact working. This second task required images that would celebrate.

Both of these kinds of images have become the most well known, but by far the most pervasive images the photographers made were those which purported to show neither the horror nor the glory of the 1930s, but images of everyday, life-as-lived: the *vernacular*. The nature of this third kind of image, virtually unknown and unanalyzed until the present day, was recognized by one FSA photographer, Ben Shahn: "We tried to present the ordinary in an extraordinary manner. But that's a paradox, because the only thing extraordinary about it was that it was so ordinary. Nobody had ever done it before, deliberately. Now it's called documentary, which I suppose is all right . . . We just took pictures that cried out to be taken."

Primary Care in the 1930s

In the forty years since the FSA's medical photographs were taken, more and more Americans have become accustomed to "seeing the doctor" more and more frequently. In the 1930s, there was an average of 2.6 medical visits annually, per person, but in any one year only half of the population saw a doctor at all. In contrast, in 1975 eight-five percent of the people had some kind of medical consultation, and the average number of yearly visits had risen to 4.5 per person. Some forty percent of those Depression visits took place in the patient's home, whereas today housecalls account for scarcely one percent of the total. By current standards, visits then were cheap: 50¢ to \$1.50 in the country, and between \$3 and \$5 in the city. Nevertheless, few working people could easily afford even such relatively meagre charges. (Median income then was \$1500 for patients and \$3000 for doctors — with marked differentials between urban and rural practitioners.) The cost of ambulatory care is less troublesome today when sixty percent of the population has some coverage of office care through Medicare, Medicaid, or private insurance. There was no such coverage in the 1930s, and as a result, urban OPDs were crowded, and country doctors ran "home style" OPDs out of their offices by simply not charging (or not collecting from) their patients; that situation continued until after World War II.

As previously noted, the FSA funded a medical plan which provided for primary care in the doctor's



Dorothea Lange: Calipatria (Imperial Valley), California



John Vachon: Oran, Missouri



John Collier: Penasco, New Mexico.



Russell Lee: Wilder, Idaho



John Vachon: Scott County, Missouri



John Collier: Bridgeton, New Jersey

office — a supposedly modern innovation that occurred four decades ago. (This development was distinct from another 1930s innovation, the Blue Cross-Blue Shield plans for hospital care.) Such FSA plans were directed towards low income farm families as well as the down and out migrants who saw doctors and nurses at FSA-supported health centers. At their peaks, the plans enrolled over 600,000 people, while the health centers treated some 150,000 migratory workers.

Medical Photographs and the Doctor-Patient Relationship

The roster of FSA photographers, given their vast accomplishment, was surprisingly small: a dozen in total, and rarely more than half that number out in the field at any one time. Giants emerged, such as Walker Evans and Dorothea Lange, Russell Lee and Arthur Rothstein and Gordon Parks. Some were newcomers to photography while others had worked at it — commercially and academically — for a decade or more. Yet whatever their training or experience, before or after, it was during their work with the FSA that they realized the height of whatever professional achievement they came to have.

The result, of course, has scarcely been approached in scope or in particularity. The FSA photographs reveal small towns and sprawling cities, flood relief efforts and embittered strikers, lonely back roads, deserted farmhouses, cemeteries, black and white sharecroppers, Chicano farmworkers, soiled miners, Southern policemen, country stores, women in cotton mills, New Bedford fishing boats,

swirling dust storms. The viewer comes away from them having seen a sweeping yet intimate inventory of working people's lives against a backdrop of a ravaged countryside, over almost a decade of time.

As the FSA turned its cameras from rural despair to rural success late in the 1930s, some photographs of medical projects appeared, although in comparison with those documenting other areas of American life, the total was slight. Preparation for World War II thereafter narrowed even further the rationale for "medical" photographs; still, a question may be raised as to why their numbers were not greater to begin with. The answer, in brief, is that medical photographs were not central to the mission of the FSA as it has come to be understood. What was central was the documentation of desperate rural conditions; medical care — good, bad or indifferent — was deemed an irrelevant component of those conditions. Hardly any of the victims of the Depression felt they "deserved" comprehensive medical care, and care providers, few in number themselves, lacked either capital or facilities to handle what was expected of them.

The Message of the FSA Medical Photographs

In a complex way, these FSA medical photographs break with an earlier tradition, an ideology that isolated doctor from patient. Prior to the making of these images, the office visit had rarely been recorded. Since antiquity, of course, drawings have depicted the doctor acting upon the patient, but absent was any sense of mutuality in the relationship. From the nineteenth century on, commercial photography increased the sheer number of medical images, and in hospital after hospital, bed patients and their nurses were photographed time and again by administrators in order to demonstrate the accommodations of their wards. Additionally, medical staffs frequently recorded themselves — and those they trained — for posterity. Yet in all of these, photographs of doctors with patients were rarely to be found; this view of the relationship remained off-limits, perhaps because of prevailing notions concerning privacy.

Perhaps. But to the extent that the act of photographing something may be said to convey value, the absence of such doctor-patient images may simply indicate that that kind of relationship was not valued. By contrast, since the great majority of FSA images do exhibit a valuing of similarly ordinary scenes, it is not by accident that among them we find "plain pictures" of "plain doctoring."

And these pictures have a growing audience today because the primary care movement is attracted to their ordinariness. Indeed, the focus — implicit or explicit — upon the doctor-patient relationship within each of these photographs may impel the viewer to consider as well the medical care delivery system, attempted in the 1930s, that resulted in this kind of relationship. Contemporary supporters of primary care medicine argue that such prepaid plans of the New Deal may provide clues to medicine's direction as it enters a new decade.



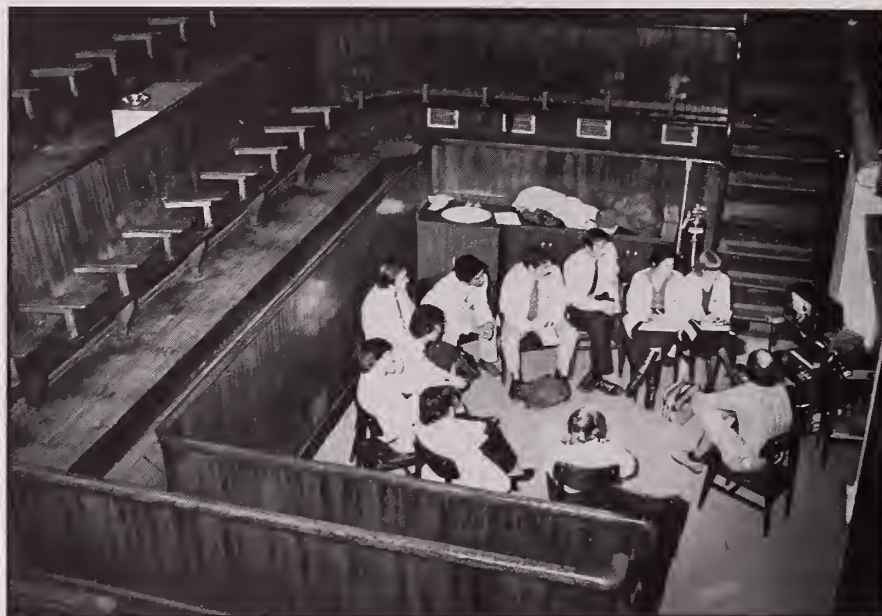
John Vachon: Chaffee, Missouri



Russell Lee: Maricopa County, Arizona



John Collier: Questa, New Mexico



by Allan Goroll

Making Room for Primary Care

The case for a core clerkship

Ten years ago, students who were considering careers as generalists had to invent their own educational experiences. Only a few clinical and classroom opportunities, primarily those offered by the Family Health Care Program at Children's Hospital and the medical outpatient department at the MGH, provided clerkships in what has come to be known as primary care. Role models were scarce and the pressures to subspecialize were extremely strong, albeit often subtle.

Primary care at Harvard is much more visible now; over fifty courses address themselves to the subject matter and clinical tasks of the discipline, and there are residency programs at the major teaching hospitals. Yet med-

ical students who want to be generalists still lack a clear sense of how to proceed. As Dr. Paul Beeson recently noted in a critique of the HMS curriculum, a number of highly specialized clinical courses are favored over those that teach the skills and responsibilities pertinent to primary care.

In contrast to Harvard, the majority of U.S. medical schools have decided that all of their students should be exposed to a clinical experience in which patient care is comprehensive, longitudinal, and coordinated; in fact many now mandate a primary care clerkship. At Harvard there is no such core requirement.

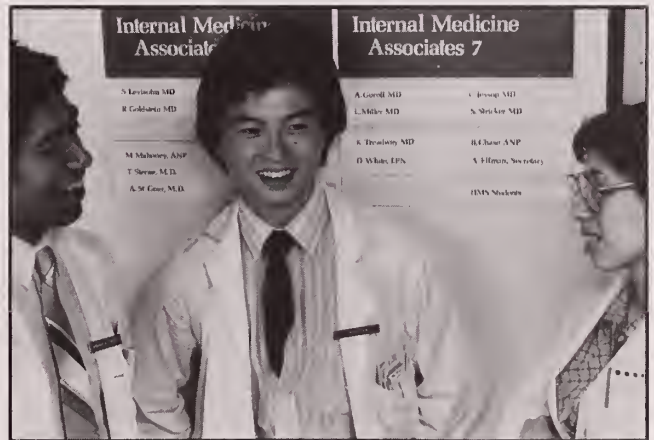
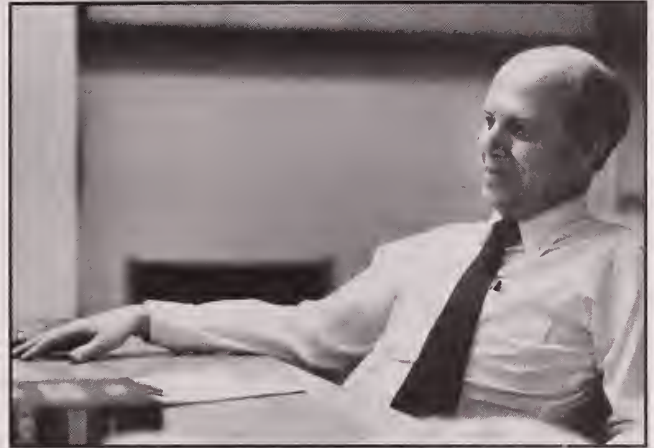
If Harvard were to establish a core clerkship in primary care, the objectives should include: a patient care milieu that facilitates continuity; a cadre of physicians who, as teachers will be effective role models; students having responsibility for comprehensive evaluations of new patients,

follow-up care, and health maintenance; an emphasis on decision making in situations of clinical uncertainty; the provision of personal as well as technically sound care; and the design of cost-effective diagnostic plans and practical management programs.

The call for a core requirement in primary care should not be merely another request for "prime time," nor should it displace other clerkships that stress fundamental skills. Rather, a core clerkship should be an attempt to assure that Harvard students develop basic competence in the provision of comprehensive, continuous, and coordinated care. If current public dissatisfaction with the medical establishment is in part related to the atrophying of primary care medicine, then we must teach students how to better meet this need, regardless of whether they become generalists or subspecialists. The skills required are generic to doctoring.

Allan Goroll '72, assistant professor of medicine, is director, undergraduate education for primary care, and course head for the introduction to clinical medicine at the MGH.

Opposite, left: Jin Hin Hahn, HMS II, is guided by Allan Goroll in the tangibles and intangibles of an examination. Opposite, right: Second year students in the introduction to clinical medicine at the MGH learn by reviewing videotapes of one another. Below, left: The parts of a physical exam are dutifully recorded and simultaneously screened. Below, upper right: John Stoeckle has been a guiding light of the primary care program at the MGH. Below, lower right: Like their classmates, Dwayne Pursley, Jin Hin Hahn, and Debbie Nichols relish their first taste of clinical medicine. As members of primary care teams, they become acquainted with a cross-section of patients.



A Sampler of Courses Pertinent to Primary Care at HMS

Primary Ambulatory Care
 Primary Care Medicine
 Advanced Primary Care Internal Medicine
 Ambulatory Medicine in the Community Hospital
 Primary Medical Care in a Psychiatric Hospital
 Preceptorship in Primary Care
 Nutrition and Rural Medicine in Latin America
 Geriatric Medicine
 Introduction to Hospice Care
 Pediatric Adolescent Gynecology
 Core Clerkship (Ambulatory MGH)
 Adolescent Medicine
 Clinical Genetics
 Pediatric Practice in Rural Maine
 Preceptorship in General Pediatrics
 Infant and Child Development
 Community Health Care of Adolescents
 Adolescent Medicine
 Health Care in Neighborhood Health Centers
 Community Medicine Clerkship at Zuni Pueblo

Primary Care Preceptorship
 Family Practice Preceptorship
 Primary Care in a Rural Setting
 Family Medicine
 Interdisciplinary Team Training
 Family Practice: Family Health Care Program
 The Social Control of Medicine
 Social Theory, Human Values, and the Health Relationship
 Psychiatry in Medicine and Surgery
 Psychosomatic Medicine in Consultation
 Psychiatry in a Community Hospital
 Human Sexuality
 The Aging of Man
 Clinical Aspects of Human Sexuality
 Surgery in a Community Hospital
 Surgery and Comprehensive Health Care
 Common Surgical Conditions seen in Primary Care

(This partial list of courses was prepared by members of the Class of 1980.)

Premedical education: beyond science

Premedical undergraduates are rarely given the opportunity to explore the historical, sociological, and psychological issues they consider relevant to their future careers. While basic science courses are dutifully taken, some students question the connection between those courses and a vocation which seems to them inherently non-quantifiable and interpersonal. "Plain Doctoring in an Age of Technological Medicine," an experimental seminar given in 1977 and 1979 at Eliot House, Harvard College, attempted to bridge this gap.

The seminar's explicit objective was to reaffirm the primacy of the doctor-patient relationship. A syllabus that had among its basic texts books as apparently dissimilar as Walker Percy's novel, *The Moviegoer*, and Freud's *Therapy and Technique* was one of the means to that end. Early in the course, the students were asked to submit autobiographical accounts of their experiences with doctors; many were generous in their praise, but some were sharply critical of what they perceived then as indifference. Further readings, class discussions, and clinical exposure began to increase the students' awareness of the inevitable subjectivity of medicine and enhanced their appreciation of how difficult it is to be a good clinician. Each student was also required to visit the MGH clinics at least three times. Paired with residents, they sat in on doctor-patient encounters.

What is clear at this point, after the trials and errors of two seminars, is simply that college undergraduates are willing and able to recognize and investigate the issues of primary care medicine and the doctor-patient relationship — and, most important, to do so before medical school, where they may become too involved with mastering the important but technical aspects of medicine to concentrate on humanistic considerations.

— Michael Grey

Grey, a Harvard College senior, was a student in the 1977 seminar and an assistant to instructors John Stoeckle and George White in 1979.

Hide and Seek

by Karl L. Singer

Some observations on family medicine at Harvard

My introduction to family medicine at Harvard came in my third year of medical school when I signed up for the elective at the Family Health Care Program. The program's building was a bit hard to find, obscured there in the shadows of the Brigham and Children's, but for me it was a ray of sunshine that illuminated areas of medical practice such as family-oriented and ambulatory care and community medicine which otherwise hardly appeared to exist at HMS. However, even though I had enjoyed the experience immensely, in 1967 family practice was too new a discipline to select for postgraduate training. I opted for a more conventional medical internship, and followed it with two years in the Indian Health Service.

The challenging variety of that type of general practice inspired me to seek a family practice residency in Boston — where I found that the only available program was in general practice at the Family Health Care Program. When I looked at what it offered I quickly lost interest; the majority of my time would have been spent in traditional hospital rotations at the Brigham and Children's. I decided instead on a medical residency at the Beth Israel, where I was permitted greater flexibility. I was able to take electives in most of the non-surgical areas of family medicine, including newborn nursery, pediatric emergencies, psychiatry, gynecology, dermatology, ophthalmology, and ENT.

After I completed my residency I

joined the department of family practice of the Exeter Clinic in Exeter, New Hampshire. I have worked there as a family practitioner for the past seven years; rarely have I lacked excitement or challenges. In a typical day I might see a six week old for a well-baby check, a child with an earache, a young woman in for contraceptive counseling, a seventy year old with myasthenia, and a forty year old depressed man. Such great variety assures that I won't get bored with my practice, unlike many pediatricians and internists who, according to recent studies, burn out after ten years of practice. The pediatricians tire of days filled with well-baby checks, earaches, and worried mothers, while the internists, after a decade, are depressed because none of their patients will ever be well and many are dying. While I see most of the kinds of patients seen by both internists and pediatricians, I also see young adults at a time when I can effect positive changes in their lifestyles that may result in improved health during their later years. Also, there is a chance to work with families that span several generations. As a further bonus, I have the opportunity to pursue two special interests — dermatology and hypnosis — which add still more diversity to my practice.

I became involved with Harvard again in 1975, when, under the aegis of the department of preventive and social medicine, I spent a month in New Mexico, this time as a preceptor in the Harvard-Zuni program. Since then, three students have taken month-long electives in family medicine with me in Exeter. In addition I have taught in the family

Karl Singer '67, president and medical director of the Exeter Clinic, Exeter, New Hampshire, is a family practitioner.

medicine course, and served as an internship advisor for a student seeking a family practice residency.

The students have responded to the preceptorship with the same kind of fresh enthusiasm I too must have exhibited back when I was first exposed to family practice. They have had an opportunity to observe the realities of day-to-day office practice, which include diagnosis and treatment based more on the history and physical examination of a patient and less on tests and investigations than is usually the case in teaching hospitals. And they have been able to see a tremendous variety of interesting and complex patients. During his month here, my last student encountered the following problems in cardiology alone: VSD, myocardial infarction, atrial fibrillation, post-MI, hypertension, SBE, ventricular tachycardia, pulmonary edema, and a six year old girl with newly discovered pulmonic stenosis.

During the entire thirteen years of my association with family medicine at Harvard, the discipline has appeared to be barely tolerated, existing on the periphery with only a handful of faculty appointments. Now, since the demise of the Family Health Care Program in 1974, about the only site in the Boston area where students can see family practitioners in action is the Family Practice Group in Cambridge. There is no department of family practice at any of the Harvard hospitals, no professor of family practice, and no family practice residency program. The new faculty appointments for family practitioners have been appended onto the department of preventive and social medicine, a department with no clinical base of operations. The attitude of the faculty toward family practice both in the past and at present is characterized by the disdain reflected in the appellation of "LMD."

On a personal level, the Harvard attitude toward family practice was brought home when the grant that initially supported the family medicine preceptorship ran out and, instead of receiving a token payment of three hundred and fifty dollars, I was asked to work for nothing — even though the student was paying tuition for that month and the Medical School was providing no services. During the pre-

ceptorship, the student spends ten hours a day, four days a week with me, so this involves a large donation of my time to HMS.

Nevertheless, I remain committed to teaching family medicine in order to show students its challenges and rewards. They are aware of the Harvard position, but they also realize that there is a world beyond Route 128 and, in that world, family practice is alive and well-accepted.

If ever the Medical School decides to recognize the legitimate academic and clinical status of family practice, several needs will become apparent. There should be a well-defined pro-

percent of all the patients who walk through the office door, even complicated patients with rare diagnoses like chronic myelogenous leukemia, ITP, and cardiomyopathy (all patients I've seen in the last month). Likewise, students should be actively encouraged or even required to take an elective in family medicine. This would serve as a humanistic counterbalance to their continuous exposure to the world of high technology and subspecialization in the tertiary-care hospitals. At present, the few family medicine courses offered are hidden away in the catalogue and rarely promoted as worthwhile endeavors.

“After all, it is said, if I can't know everything about my tiny part of the universe, how can you presume to know something about almost everything?”

gram for medical students and perhaps a family practice residency as well. Since the current Harvard hospitals are unlikely to give up turf to such a department, it should probably be established at a community hospital where there are a substantial number of family practitioners already on the staff. A source of funding will have to be found to implement any new programs, and since federal monies seem to be limited, perhaps the alumni could be called into service. A large donor might be found who would be willing and able to underwrite the expansion of family medicine at HMS.

Above and beyond these practical, logistical necessities, however, it is essential that faculty members learn more about family practice. Harvard is so filled with subspecialists that even the idea of functioning as a general internist or pediatrician — much less a family practitioner — seems hard to swallow. After all, it is said, if I can't know everything about my tiny part of the universe, how can you presume to know something about almost everything? And yet, a well-trained family practitioner with good back-up can take care of ninety-five

In general, I am very pessimistic about the prospects for a significant role for family medicine at the Harvard Medical School. In the absence of any kind of commitment from the faculty or administration, the only really hopeful sign is the growing interest of the students. According to my internship advisee, members of the faculty are now being forced to take notice since some of their best students are applying to family practice training programs. Alumni, particularly those who are themselves in family practice, might also play an important part; in fact some of them may well want to earmark all of their contributions for the support of this discipline. For the time being, at least, the future of family medicine at Harvard seems to be in the hands of these two groups.

by John D. Stoeckle
Richard L. Goldstein
Jerome H. Grossman
Alexander Leaf

Facing the Crunch

The need to work more and learn outside the hospital

Once upon a more prosperous time, it looked as if the economy of the United States would be able to absorb the costs of continuous, unlimited medical expansion. Now, however, in an era of retrenchment, HEW is seeking Congressional sanction to cut back the capitation grants that subsidize medical education — in the express hope that the schools will then reduce enrollments. If that doesn't happen, there soon may be more doctors (and services) than the public can pay for — more, perhaps, than it even needs. Yet the spectre of a diminishing medical work force alarms both the public and the profession. They envision less medical care — when it still seems hard to get a doctor; fewer career opportunities — when it remains difficult to get into medical school; and, overall, less diagnostic testing and treatment — when all of the procedures now in common use seem so essential for good and proper care.

One possible redirection that seems economically feasible, and that might also be more generally acceptable than a reduction in medical manpower, would involve a shift in some medical practice and training toward ambulatory, labor-intensive primary care. A greater number of doctors could then practice, but they would need fewer of the increasingly complex and expensive hospital technologies. That kind of care would be particularly appropriate for preventive medicine and the long-term treatment of chronically ill and aged patients.

More will be said presently about the implications of increased future emphasis on primary care. But first, some attention to past patterns of growth in health manpower

may be helpful. At the end of World War II, the United States was a wealthy nation. Throughout the 1950s and 60s, personal incomes in the U.S. rose yearly, and people were willing to use part of their larger wages and salaries to pay out-of-pocket for more health care and — they hoped — better health. Industry also readily paid out large sums for protective benefits for workers. Organized labor, which during the war had accepted industry's offer of hospital insurance in lieu of wage increases, afterwards negotiated for both hospital and even some out-of-hospital insurance in contracts that provided higher pay as well. Simultaneously, the government used tax dollars gleaned from the higher per capita incomes to finance the Medicare (1964) and Medicaid (1965) acts, thus taking care of health costs for the elderly, poor, and disabled members of the population. And at the same time that workers, their employers, and the government all were buying more health care, the government was also liberally supporting medical research in the medical schools and investing generously in health manpower in order to make medical services more available.

Between 1950 and 1979, larger medical school enrollments (the total for first year classes leaped from 7900 to 16,000) and heavy investments (in twenty years a total of twenty-one billion dollars, concentrated mostly in the hospitals) were intended to restore the proper numbers and types of practitioners — particularly, to reverse a decline in generalist care that began in the 1930s. The politicians were guided by the assumption that a market flooded with doctors would automatically produce the proper mix of specialist and generalists — and that the public would be able to afford whatever number of doctors and medical services it wanted. This ostensibly laissez-faire policy did make care more available, as more doctors were trained, although access to them still varies from town to country, suburb to inner city. But the policy did not alter the mix of practitioners. Between 1963 and 1976 the number of primary care physicians (i.e., in general and family practice, internal medicine, and pediatrics) grew, but their slice of the "specialty" pie actually shrank, from 42.1 to 39.0 percent.

John D. Stoeckle '47, associate professor of medicine at the Massachusetts General Hospital, has for some two decades been director of the hospital's medical clinics. Last spring he was chosen the master of the newly created Richard C. Cabot Academic Society, intended to promote matters of primary care at the Medical School. His co-authors are also involved in the Primary Care Program at the MGH: Richard Goldstein, M.D., instructor in medicine, Jerome Grossman, M.D., assistant professor of medicine, and Alexander Leaf, M.D., Jackson Professor of Clinical Medicine and head of the department of medicine.

Two factors seem to have had an important effect on what actually occurred during this period, stated policy aims to the contrary. The nature of manpower investments had sent medical education into the hospitals, where specialty training could be acted out, and where the system of reimbursement — from government insurance programs, as well as private insurers — continued to reward specialty services more favorably than generalist care. Moreover, several federal and institutional policies that were seldom acknowledged to be about manpower conflicted with the promise of a better doctor mix — by in fact facilitating more specialization. The government funded research and clinical training with fellowships directly allocated to specific subspecialties, and still other, similar fellowships were financed by hospitals out of their charges for services and thus, indirectly, by private and public insurance. Since these advanced programs were established in response to the needs perceived by hospitals, their subspecialty departments, and the national subspecialty societies, they were seldom called upon to justify the services they provided. Like the federal grants, the hospital programs also undercut the idea of general training — at least in medicine, where such training was reduced in favor of early specialization. The obvious educational message was that the professional competence of a generalist always would be incomplete.

In what is by now familiar history, federal and state policy makers ultimately did intervene with new incentives for primary care training, in order to produce “the right number and the right kind” of doctors (more in primary care, fewer surgeons, and a continuation of current levels in other specialties). In 1969, government grants provided direct support for residency training based in model family practice units outside of the hospital; by 1976, the terms of capitation funding required medical schools to organize at least half of their postgraduate residencies in the primary care specialties of internal medicine, family practice, and pediatrics; and in 1976, the provisions of federal grants added pediatrics and internal medicine to the ranks of those programs that could be supported if based partly in practice outside the hospital.

Since 1968, when only 29.4 percent of all first year residents opted for training in primary care specialties, there has been a desirable increase; in 1978, fifty percent made that choice. However, because decisions to enter medical subspecialties occur after the first, second, or third years of residency rather than at the end of medical school, it seems too soon to evaluate the real impact of the new policies. (For a preliminary report, see Robert Lawrence’s article, which begins on page 6.) Meanwhile, the hospital-centered pattern of medical training and practice remains the professional standard, regardless of specialty. For example, in internal medicine, the most popular primary care specialty, that kind of training is underwritten not only by hospital insurance, but also by the assumption that medical work inside the hospital will continue to grow as it has in the recent past. Nearly half of the work of practicing internists is presently based in the hospital, as compared with only a quarter, fifteen years ago. Can this pattern of expanding hospital services and medical work continue as the number of doctors grows ever larger?

A decision to hang onto that status quo would in turn

require two things: a continuing, supposedly “hands-off” governmental attitude towards medical career choices and the mix of specialties; and sufficient economic prosperity to permit more and more support from federal and private insurers for the current hospital-based model of medical services and training. Neither dream seems likely to come true — when, in sharp contrast to the steady economic growth of the preceding decades that supported the expansion of medical manpower and hospital services, the 1970s have seen real personal incomes decline as energy costs, defense spending, and inflation have spiraled upwards at ever faster rates. Rather than further expansion, substantial cutbacks in federal expenditures seem inevitable and imminent, and likely to have a noticeable effect on the numbers and kinds of health care services available to the general population. In a restricted economy, another possibility would be simply less of everything, across the board, including even more limited investments in out-of-hospital services and, as a result, less work for the surplus of doctors.

However, as suggested earlier, an increase in primary care could provide still another, perhaps more reasonable, future scenario for medical education and practice. Greater emphasis on ambulatory medicine — which requires a labor-intensive output from physicians themselves — could mean medical work for the potential “surplus” of M.D.’s, while spending for costly technical and hospital services is contained. Already, yearly hospital admissions per physician are beginning to decrease, and medical subspecialists currently spend a significant portion of practice time in the general care of patients, thus disguising their underemployment as subspecialists. Threatened by the implications of a shrinking inpatient census and less ample funding for expensive technologies, hospitals may develop ambulatory group practices and facilities for long-term care — in order to maintain their institutional domain. (Several hospital-based group practices in general medicine have been backed by an eight million dollar Johnson Foundation grant program, administered by Dr. Richard Nesson at the Peter Bent Brigham Hospital.) If health care spending does become limited, the government could promulgate policies that favor primary care services over highly technical interventions. Such a reallocation of resources, along with altered reimbursement schemes and new investments in insurance coverage for ambulatory care, would mean more medical work outside the hospital, and might also create new pressures for more training of the doctor in medical practices.

Yet any such moves are problematic. They will be certain to raise a number of sensitive issues, as conflicting goals lead to compromises and doctors are forced to make difficult choices in an altered job market. Thus the respective merits of capital-intensive advanced technologies and labor-intensive primary care will have to be weighed, and hospital administrators will be compelled to deal with the demands of hospital-trained physicians for hospital appointments, even when there may seem to be less than enough work to go around. In the search for jobs for doctors, nurse practitioners and physician assistants may find their work repossessed by M.D.’s. Additional regulation of medical work may create administrative, if not clinical, positions for doctors willing to supervise their professional

“The future does promise improvement in long-term primary care and the prevention of disability, if not also disease.”



Ann St. Goar '79, a first year resident at the MGH, practices with Internal Medicine Associates, a hospital-affiliated primary care group practice.

peers. Practices might be divided up — so that two doctors would do the work now done by one, but without sacrificing too great a part of their present income. And the competition for medical jobs may spearhead a drive for equal pay regardless of specialty training. Willing or not, hospitals that organize ambulatory practices may also have to decentralize their traditional clinical and administrative authority.

Amid such possibilities, perhaps the medical schools and teaching hospitals will reevaluate their emphasis (during the last few decades) on hospital-based training, and then will work to improve treatment and expand learning outside the hospital. Ambulatory practice has its own distinctive set of educational imperatives, and adjustments in philosophy as well as curriculum might be made to accommodate them. Laboratory research, the mainstay of the hospital and the rational basis for its technology may have to share the spotlight with research that, for example, looks at the outcome of the technologies and medical services that hospitals and practices provide. (The hypertension treatment studies of Dr. James Taylor and staff at the East Boston Health Center are good examples.)

Regardless of how these possibilities are ultimately mixed and matched, the future does promise improvement in long-term primary care and the prevention of disability, if not also disease. The government is presently trying to find ways to contain the costs of acute hospitals and to assess their technology, while students, with their keen sense of the job market, are increasingly seeking careers in primary care both at and away from the medical centers. Reimbursement formulas, now a topic of health services research, are being openly examined by third parties who may begin to look more favorably on the value of personal contact as a basis for payment. Some community hospitals and academic medical centers are working to incorporate out-of-hospital practices — not only to maintain a useful institutional domain, but also to develop new teaching and research, and medical faculty members are being recruited for patient care, teaching, and research that is now located in these general medicine group practices. Though not new to Harvard — with its old affiliated community-based hospitals — this development introduces a new class of doctors, practices, and patients into modern academic medical centers that were organized primarily as referral centers. Implicit in all of these stirrings are the hopes for better treatment and education — which will become more than hospital medicine — and of course, future jobs — fully engrossing, useful medical work — for everyone.

Policies, procedures — and people

I read with great interest and appreciation the February issue of the *Bulletin* which included a summary of my remarks before the Alumni Council, and also the Report of the Ad Hoc Committee on Admission Policies and Procedures. The Ad Hoc Committee did an excellent job and it was heartening to have it essentially endorse our current mode of operation. I should like however to go beyond the favorable tone of the report to indicate that we should all be deeply appreciative of the truly outstanding contributions of the people involved. The nearly seventy faculty members and students work hard, often for long hours, with singular dedication, skill, fairness, and enthusiasm. The members of the office staff also carry a very heavy load for much of the year and do their best to handle the many pressing applicant problems patiently and thoughtfully and efficiently. To all of them, without whom the process is meaningless, our especial thanks.

Oglesby Paul '42

Family practice: strictly speaking

I was shocked to learn that Dr. Curtis Prout is still advising medical students and alumni that "no strictly family practice programs exist in New England." (*Alumni Bulletin*, February 1980, p. 14.) Apparently Dr. Prout is unaware of the University of Massachusetts Family Practice Program, which has been accepting residents since 1974, and graduated its first residents in 1976. Perhaps he has forgotten those of us whom he personally advised at Harvard Medical School who entered the U-Mass. program: Lucy Candib '72, Daniel Doyle '74, Rachel Wheeler '77, Susan Okie '78,

Amy Schneider '78, and upon graduation this year, Annmarie Errichetti, '80.

I take it Dr. Prout is also uninformed about the ten other accredited family practice programs in New England outside Massachusetts — four in Maine, three in Connecticut, one in Vermont, one in Rhode Island, and one in Albany, New York. I presume Dr. Prout has not yet heard of the newly accredited family practice programs in Massachusetts: in Fitchburg, affiliated with U-Mass; and at the New England Memorial Hospital in Stoneham. These thirteen residencies will have 204 residents in "strictly family practice" in New England in July 1980. I can only conclude that Dr. Prout believes that New England lies within Route 128, or perhaps within the Harvard Medical area itself.

If this kind of misinformation is typical of what Harvard students, alumni, and faculty are learning about family practice these days, it is no surprise that family practice still has a negative image at Harvard. Perhaps Dr. Prout should follow his own recommendation that explorations regarding family practice be taken "to the highest levels" by making a tour of the thirteen family practice programs in New England. I'm sure that a number of Harvard alumni who are family physicians would be glad to advise him on his itinerary. Geoffrey Modest '73 and Dr. Lucy Candib are currently faculty members in the U-Mass. program. Karl Singer '67 is now the medical director of the Exeter Clinic in Exeter, New Hampshire, where he practices family medicine with James Tucker '54.

Perhaps Dr. Prout would be interested to learn of Dr. William Damon, a family physician who offers Harvard students a family practice elective in Gardner, Mass. Unlike Dr. Prout, Dr. Damon has influenced a number of Harvard students to enter

family practice. He recently joined the faculty of the department of family and community medicine at U-Mass.

Maybe Dr. Prout would like to meet the U-Mass. residency trained family physicians now in practice in Massachusetts in Somerville, Needham, Worcester, Holden, Barre, Southbridge, Shelburne Falls, and Greenfield, as well as in Cavendish, Vermont. Perhaps after such a tour Dr. Prout would no longer feel compelled to continue offering the advice we received as students interested in family practice, namely, to "consider primary care medicine or pediatrics" instead.

If Dr. Prout or other alumni or students are interested in learning more about family practice in New England, a friendly inquiry at the department of family and community medicine at the University of Massachusetts Medical School would be warmly received. To those brave souls who would venture beyond Route 128, we would gladly offer a guided tour of our program and provide information about other family practice programs in New England.

Lucy Candib '72
Rachel Wheeler '77

Dr. Prout replies:

Of course Drs. Candib and Wheeler are correct. I certainly know of the programs in New England and have visited some of them. What I thought I said was that there are no family practice programs directly affiliated with the Harvard Medical School.

Praise for the prose

I have just finished reading the new (February 1980) issue of the *Harvard Medical Alumni Bulletin*. I am always amazed and captivated by the quality of the writing — not merely the content! Thank you for one of my real joys and highlights.

Maxine T. Clarke, M.D.

Vanderbilt memories

I would like to share my reaction to the rehabilitation of Vanderbilt Hall. Although I am usually sympathetic to Harvard Medical School alumni requests and read such mail with interest, when the request for funds for this project arrived, I promptly tore it in two and deposited it in the wastebasket. Surprised at the vehemence of my own reaction, I gave the matter some thought.

Back in the '50s, Vanderbilt Hall was a *men's* dormitory, and we pitifully few HMS females were forced to live in apartments, furnished rooms, and boarding houses in the area. This physical dispersion further decreased our ability to identify as a group. Although we were allowed to take meals at the dorm, the necessity to travel (in those times, mostly on foot and public conveyance) made this impractical. The school never offered, nor did we have the brains or guts to demand, or even request, that a wing, a floor or a fraction of a corridor be reserved for us. My anger was thus directed mainly toward myself because of my passive acceptance, as a student, of the status quo.

I trust that conditions are very different today, and that the blatant prejudice of those times is no longer evident. Does any current HMS woman receive an angry lecture from her OB instructor, as I did, to the effect that I should be out having babies instead of taking up a man's place in medical school? Are the writeups and discussions of surgical procedures still conducted in the doctor's (read *male's*) dressing room, while the female students share a cup of coffee with the nurses?

Sheila B. Blume '58

Exemplary

The fall 1979 issue of the *Harvard Medical Alumni Bulletin* with its focus on fitness shows us that Harvard trained individuals are again in the forefront of the latest trends in medicine. Preventive medicine is clearly the wave of the future and Harvard graduates will help provide the leadership in this field as they have

in countless others. They will train researchers, teachers, and practitioners, who will spread the word that proper exercise and diet are essential in guaranteeing longevity and good health.

A special mention must be made of Dr. Paul E. Spangler's essay. An eighty-two year old man who states "My health has never been better," cannot be passed over lightly. In my primary care clinic practice, where ninety per cent of my time is spent instructing patients in proper nutrition, exercises, and the like, I have used Dr. Spangler's article to inspire my patients as it has inspired myself. Most of them have been amazed, and his example has helped motivate them to begin their own exercise programs.

I believe Dr. Spangler will be legendary. We can all be encouraged by his example.

Robert Taylor '77

Running into trouble

What follows is a short rebuttal to the fall 1979 issue, "Fitness on the Run." It might best be entitled "All that glitters is not gold." At any rate, I am back working full time, am totally intact neurologically, and have a normal heart. I am limiting my exercise a bit, but did want to quote that New England philosopher, Ralph Waldo Emerson, who stated that "every excess causes a defect, every defect an excess. Every faculty which is a receiver of pleasure has an equal penalty put on its abuse, with every influx of light comes new danger, there is a crack in everything God has made. It would seem there is always this vindictive circumstance stealing in on us unawares, this backstroke, this kick of the gun certifying that law is fatal, that in nature nothing can be given, all things are sold."

The first days of June 1979 had been extremely busy. There had been cases added on at the medical school and others to wrap up here at the hospital prior to departing for the Samson Thoracic Surgical Meeting in Boise. There my wife Joan and I entered a 10,000 meter run and she noticed that, for the first time, I stayed back a bit at the start, and it was only later that I passed her. We gave this no further thought. After the completion

of the meeting with its usual extended activities, I completed a fifty mile endurance ride on my favorite horse Red. It was the fifth completed ride of the spring and we were standing fifth in the nation on points at its completion. Such events require a lot of running beside the horse to conserve his energy.

On return to Portland, Oregon the weather was warm and muggy. After several late meetings of our hospital executive committee as well as several operative cases, during the first three days at home, I turned out for my usual six mile run. From here on this recounting is purely hearsay as I do not remember the events that followed. I was found lying face down along the roadside by one of our operating room nurses who was on her way home. I was found at the top of a hill which in preceding months had frequently challenged my determination and produced frustration whenever I had to come to a stop on it.

At any rate, the scrub nurse had taken a CPR course some six years before, and called on her retentive memory to initiate resuscitation. She hailed a woman watering her lawn who telephoned for an ambulance and then came to assist her in her resuscitative efforts. Medically, the rest is simply history. Having been successfully defibrillated, I was taken the remaining mile and a half to the hospital by ambulance. I went through an uneventful convalescence, following coronary angiography which revealed normal coronary vessels, a normal ventricle and normal ejection fraction. This was a totally unexpected blessing, for my family is particularly afflicted with coronary disease. Since that time I have engaged in a rehabilitation program of jogging, have had numerous exercise stress tests, including one at extreme exertion — over thirty minutes — with serial serum potassiums determinations and EKG being well within the normal range.

The days since that event in June have been filled with a steady and progressive recovery during which I have been queried by cultists and food fadists as well as psychologists who are interested in near death experiences. I can only say that it was as though I went to sleep about Memorial Day and woke up on the Fourth of July. The experience has left me

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